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## An Impact Study of the Community Mental Health Program in Western Region, Nepal



by

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2004, May

*Dedicated*

*To all the mentally ill person of western region of Nepal*



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In 1984 the United Mission to Nepal initiated a Mental Health Program, with a particular mandate to consider the needs of the mentally ill in Nepal who are not reaching specialist services; and to investigate the possibilities of integrating mental health care for them into existing community health care structures. Since the beginning, United Mission to Nepal has started its Mental Health Program with its main focus on building up and developing community mental health programs. Mental Health Program, United Mission to Nepal has already worked hard in two community mental health programs, Central region (Lalitpur District) and Eastern region (Morang District) in the process of developing community mental health programs.

Western Region Community Mental Health Program (WRCMHP) is the only large community mental health program in Nepal at this time. It has been implemented by Mental Health Project, Institute of Medicine, T.U. with active partnership of Mental Health Program, United Mission to Nepal since 1992. WRCMHP has almost completed its fourth phase in twelve years time period. Though the program has been evaluated both internally and externally at different time intervals, its impact on different levels of community and at a national level has not been fully studied. This study aims to address the impact of WRCMHP from different perspectives of beneficiaries in the program.

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## Abbreviation List

CDHP	: Community Development Health Program
HMG	: His Majesty the Government
HP	: Health Post
PHC	: Primary Health Center
SHP	: Sub Health Post
SPSS	: Statistic Package for Social Science
TUTH	: Tribhuvan University Teaching Hospital
UMN	: United Mission to Nepal
WRCMHP	: Western Region Community Mental Health Program
ANOVA	: Analysis of variance
HA	: Health Assistance
CMA	: Community Medical Auxiliaries
AHW	: Auxiliary Health Workers
SAHW	: Senior Auxiliary Health Workers
ANM	: Auxiliary Nurse Midwives
HMIS	: Health Management, Information System
MHP	: Mental Health Project
IOM	: Institute of Medicine
MHP	: Mental Health Program
FCHV	: Female Community Health Volunteers
TBA	: Traditional Birth Attendance
VDC	: Village Development Committee
SRQ	: Self-Reporting Questionnaire
GP	: General Practitioners
CDP	: Community Drug Program
MBBS	: Bachelor of Medicine and Bachelor of Surgery

MAP OF WESTERN REGION SHOWING THE DISTRICT WHERE  
COMMUNITY MENTAL HEALTH PROGRAM IMPLEMENTED

- ☐ First Phase 1992-93
- ▨ Second Phase 1993-96
- ▩ Third Phase 1996/97-2000
- Fourth Phase 2001-04



Mental health program was not implemented in an unshaded area of western region in the map



## **Abstract**

The impact study of western region community mental health program (WRCMHP) aimed to evaluate outcomes of the community mental health service that has been operating for more than eleven years in selected districts of western region of Nepal. The study followed experimental-control study design and used both quantitative and qualitative approach to analyze data. Information was collected from healthworkers, mental patients and their relatives and community people. A control group was selected for all informants except mental patient and their relatives. Purposive sampling technique was used for the health workers population while patients were randomly taken from Health post / Primary Health Center registers except in Kaski district where all available patients were interviewed. Community focus groups were purposively selected following selection criteria developed for the study. The control group sample was selected from the HP / PHC and community where community mental health services are not available. It was assumed that the current program of WRCMHP had no influence both in service and awareness area of mental health in these areas. Sample population ratio for health workers between experimental and control group is 51:49.

Healthworkers in both groups were firstly given a demographic information sheet followed by a mental health training evaluation questionnaire, case evaluation form and attitude questionnaire form. The participants wrote information in the questionnaire form. The patient interview form was used to interview mental patients visited at the health post / primary health center. Patient relatives were also interviewed where available. The psychiatrist, following patient examination form, evaluated patients. The community focus group discussions were conducted with the use of a structured questionnaire. Following collection, the data was analyzed using SPSS software version 10.0 for the descriptive study. Qualitative methods were used to categorize and conceptualize attitude related information. Findings were compared between two groups i.e. control and experimental.

Findings revealed that the difference in work experience, total scores in mental health training evaluation questionnaire and the scores on the case evaluation form were highly significant when compared with the control group. It indicated that trained health staff were able to maintain mental health knowledge and skills effectively. Individual case profile scores on the case evaluation form revealed that trained health workers were more efficient in diagnosing and treating each case than the control group, except in the case of epilepsy. Since this condition is included in the curriculum of health workers, there was no significant difference in knowledge and skill for the diagnosis and treatment in the two groups. The diagnosis and treatment pattern of health workers in the experimental group had a high degree of agreement with psychiatrist regarding diagnosis and treatment, which further proved the effectiveness of training to health workers.

Patient sample analysis revealed a wide dispersion in duration of illness before attending a health post, duration of treatment from health post, travel distance from health facilities to home and waiting time to consult health workers in health facilities. Majority (61%) patients were female, with housewife as major occupation. Qualitative information from

patients revealed that mental health service in health post was effective as they were getting service at cheaper rate in their own community. There is evidence of decreasing stigma against mental illness and increased attitude of service seeking from local health facilities (HP / PHC) among the community people.

Qualitative information from healthworkers revealed that mental health services are effective in strengthening capacity of healthworkers, increasing availability of mental health services in community and in reducing the stigma of mental illness. However, health workers reported facing problems such as lack of regular medication supply, lack of trained health workers in mental health, no integration of mental health services into existing health service system (such as separate mental health clinic in particular day of a month, separate recording system than modifying existing reporting system (HMIS) and exclusion of psychotropic drugs in essential drug lists). The sustainability of current community mental health services is crucial because of lack of adequate support and motivation in HMG. Implementation of the findings and its recommendation can be a key issue in answering the questions regarding the sustainability of community mental health service in the western region.



## 1.0 Introduction

Nepal is a relatively small country of varied terrain ranging from the magnificent Himalayas in the north to the plains of the Tarai in the south, with the beautiful middle hills in between. The country has a total population of 23 million (Nepal in figure, 2002). Of the total population only 14.2% reside in urban areas and communication and transportation issues are problematic (CBS, 2002). The G.N.P. per capita is US\$ 210 and 42% of the population are below the poverty line (UNDP, 2000). Life expectancy at birth is 59.7 years, the literacy rate is only 53.7% (CBS, 2002) and the under-five mortality is 107 per 1000 live births (World bank, 2000). Administratively the country is organized into five development regions, 14 zones, and 75 districts. In regards to the medical services of Nepal, the majority of the 12,000 doctors and of the hospital beds (hospital beds to population ratio 1:4,000) are in the urban areas. The District Public Health Offices supervise the Health Posts, staffed by paramedical workers, which are the backbone of the public health system.

Mental health is very important from the perspective of health as it is said that there is no health without mental health. World health organization has rightly emphasized the concept of mental health in the definition of health. It said that health is not merely the absence of disease or infirmity but it is a state of physical, mental and social wellbeing. Mental health is a multi-dimensional concept. Normality in mental health is a state of absence of pathology (Offer and Sabshin, 1984)<sup>1</sup>. Mental health is the capacity of the individual, the group, and the environment to interact with one another in ways that promote subjective well being, the optimal developmental and use of mental abilities (cognitive, affective and relational), achievement of individual and collective goals consistent with the justice and attainment and preservation of condition of fundamental equality (Dennerstein et al, 1993)<sup>2</sup>.

Community mental health services defined by Katz (1979)<sup>3</sup> as " Organised, inter-related constellation of direct and indirect community services that contribute to the maintenance and improvement of the emotional and or mental health of citizens in a specific geographic area". This definition not only highlights the essential components of community mental health but also demands the need of inter-relationship among the various components. Further more the aim of such service is to be in the preventive and promotive aspect of mental health of peoples in a specific geographic location

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<sup>1</sup> In Friedrich, G. and Regmi, M.P. (1997) Study of Mental Health Indicators of the Nepalese Mothers (page).

<sup>2</sup> *ibid*

<sup>3</sup> In Nepal, M.K., Sharma, V.D. & Koirala, N.R. eds. Proceedings of National Seminar on "Implementation of National Mental Health Policy: Accelerating the Rate and Meeting the Challenges" & Symposium on "Alternative Approaches to Mental Health Services"



WHO (1986)<sup>4</sup> stated that mental, neurological and psychological disorders constitute an enormous public health burden. A comprehensive program directed against their biological and social causes could substantially reduce suffering, the distraction of human potential and economic loss. This statement affirms need of the prevention of the mental, neurological and psychological disorders because such conditions affect every aspect of an individual's life. In addition these problems also affect families and society as a whole. World Bank report (1993)<sup>5</sup> showed that psychiatric conditions are responsible for little more than 1% of deaths, however they account for almost 11% of disease burden worldwide and the figure is projected to almost 15% in 2020. Similarly, of the 10 leading causes of disability worldwide measured in years lived with a disability five are psychiatric conditions such as unipolar depression, alcohol abuse, manic depression, schizophrenia and obsessive compulsive disorders. The same source also highlighted that depression alone is responsible for more than one in every ten years of life lived with a disability worldwide. So these statistics are equally applicable in Nepal. The consequences of disability are enormous in our country because of extreme lack of mental health services in the country.

Another source stated that 23% of employees with psychiatric conditions lost their jobs within a 5 year period and finally ended up unemployed or disabled (McDonnell-Douglas, 1990)<sup>6</sup>. So the consequence of disability is extremely difficult and could not be compensated if intervention approach has not reached to the grass root level.

## 1.1 Mental health in the world

There is no doubt human being have been subjected to tremendous changes in their life due to development of newer scientific technology. The continuous changes in the medical and biological sciences bring newer technology to fight against many life-killing diseases. Despite these advances, we are still faced with not only physical health problems but also many mental health problems. Rapid urbanization brought about many challenges and stresses to human beings, due to increased demand of capacity to cope with the stressful situations. It is essential to develop and sustain capacity to adjust with daily life situations in the quick advancing age. So the developed countries, though they can fight with many physical diseases, are facing problems in mental health because there have been rapid increases in mental health problems.

Though WHO, in 1978, emphasized mental and social component in the definition of health, there has been several practical barriers to provide mental health service according to the need of the people in many countries in the world. Firstly, many countries are struggling with the earlier stages of national development and typically assign low priority to social welfare matters and psychiatric services usually find themselves as the Cinderella of the health care budget (Higginbotham, 1979)<sup>7</sup>.

<sup>4</sup> ibid

<sup>5</sup> ibid

<sup>6</sup> ibid

<sup>7</sup> In Adhikari, K.P. & Deninson, B.D.B. (1999) Mental Health in Nepal: A Community Survey of a village Lalitpur, Central Nepal. Mental Health Program, United Mission to Nepal.



It is true that mental illness does not make the sufferer die quickly as physical illness can, yet the burden of mental diseases is much higher as proved by research carried out by world bank (1993, 2000), WHO (1986) and other research scholars (Desjarlais et al, 1995; Wittchen & Essau, 1990)<sup>8</sup>.

Mental health problems estimated differently in different parts of the world, comparably the west and east. It is obvious that various factors affect in the prevalence of mental health problems such as geographical location, satisfaction of basic needs, safety, and accessibility to resources and opportunities to meet the demands of daily life. There has not been much difference in the prevalence of severe mental illness worldwide but the rate varies a lot for mental illnesses of moderate to mild in severity such as depression, neurotic disorders, substance abuse disorder and personality problems. The available data on prevalence of mental illness could not be free from various methodological limitations such as sample size, sample selection criteria and methods of data collections. The study completed on primary health care services showed a higher rate of prevalence which is lesser in general sample (Mubbashar, 1996; Desjarlais, 1995; Wright et al, 1990, Harding et al. 1980)<sup>9</sup>.

Mental health services are facing problems throughout the world because of very limited mental health manpower, low priority by government for mental health and lack of awareness among public. These problems affect in planning and implementation phase when providing mental health services.

The concept of community mental health services is not a new one. Over the past forty years, in every continent, mental health practitioners and planners sought have sought ways to provide more appropriate and accessible services to the needy people. In 1966 professor Michael Shepherd from the U.K. was already saying, "The cardinal requirement for improvement of mental health services is not large expansion and proliferation of psychiatric agencies, but a strengthening of the primary care doctor in therapeutic role." The Alma Ata Declaration of 1978 rightly emphasized the promotion of mental health stating that mental health is a necessary component of primary health care. Even before in 1975 WHO stated that the need of detection and management of priority mental disorders should form a part of the regular work of primary health workers (Wright, 1991)<sup>10</sup>.

There has been growing awareness, both in west and east, that effective mental health care must be based on existing general health care structures i.e. an integrated approach, with specialist psychiatric services providing a tertiary level of clinical care, a training role, a supervisory function, a lead in formulating health planning for mental health care services appropriate to the existing health care structures. In some countries such services have included the formation of mobile teams of psychiatrists or psychiatric nurses to

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<sup>8</sup> *ibid*

<sup>9</sup> *ibid*

<sup>10</sup> In Five Years of Community Mental Health Services, An Evaluation Report. Mental Health Program, United Mission to Nepal, Page 3-4.



establish area clinics; mental health camps; and the training and supervision of medical practitioners in existing health services. In 1974 a WHO expert committee considered the question of "Organization of Mental Health Services in Developing Countries", and urged member countries to recognize mental disorder as a problem of high priority for the individual, the community, and for national development. They recommended that countries should, in the first instance, carry out one or more pilot programs to test the practicability of including basic mental health care into an already existing program of health care in a defined urban or rural population. The development of simple training manual for the training was also suggested (Wright, 1991)<sup>11</sup>.

## **1.2 Health and mental health service delivery system in Nepal**

The health service profile of Nepal has been heavily dependent upon the grass root level health manpower such as paramedical and nursing staff. Primary health care center (PHC), health post and sub health post are the major grass root level health service delivery system of the country. A district hospital staffed by a medical doctor and supportive paramedical and nursing staff works as a general referral center for these grass root level health services. PHC are based on the electoral constituencies in the country, so there are 205 in total throughout the country. All the health posts sub serve under the PHC and sub health post under the health post. Basic services of these systems involve maternity and child health clinics, immunization, DOTS, IMCI, general health care service, family planning and health education.

Mental health has not yet been incorporated, as a component of the primary health care service, although Nepal is signatory of the Alma Ata Declaration that highlighted the need of inclusion of mental health into the primary health care system. Unfortunately, it is not available as a regular health service except in the area where WRCMHP serves. Paramedics and nursing curriculum had not included the mental health course during training periods. So, mental health is excluded from the beginning of the development of health manpower.

The government of Nepal did not view mental health service as a priority as it is still facing the challenges of major common killing diseases for children (Diarrhea, malnutrition, communicable diseases, accident etc) and other age groups as well. Therefore the service delivery, in regards to mental health remains unchanged. However, mental health input has been incorporated into the basic health course and also into the MBBS (Braganza et al, 1999). The former is a very short introductory course which is not sufficient to learn clinical skills in mental health while the latter involves a more detailed content in mental health with clinical skill learning so that they can provide service after graduation.

Mental health is one of the low priority programs from HMG, separate to physical health problems. In addition, there are few mental health professionals in the country. There is only one national mental hospital which is located in Kathmandu valley with the staff

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<sup>11</sup> *ibid*



comprising of only a few mental health specialists (two psychiatrists) and nurses. Psychiatric services are available from other areas of the country including Koshi Zonal hospital, Pokhara regional hospital and Bheri Zonal Hospital Nepalgunj, Lumbini Zonal hospital Butawal, and Bharatpur hospital at present through the government health system. However, psychiatric services are provided through private medical colleges established in different parts of the country such as Kathmandu, Pokhara, Bhairahawa, Bharatpur and Nepalgunj. Treatment of mental illness often demands a multidisciplinary approach for better recovery. A complete mental health team is necessary to address the bio-psychosocial approach to treatment. This team includes Psychiatrist, Clinical Psychologists / Psychotherapists, Psychiatric Nurses, Occupational therapists and Psychiatric Social Workers. Psychiatric treatment (biological), is the only approach available in the government health delivery system. Though the clinical psychologists are working in some of the teaching hospitals in the country, psychological services are not even available in the mental hospital.

In Nepal a pilot program was initiated in 1984 as an integrated part of the UMN's Community Development and Health Program (CDHP) in Lalitpur district to investigate the feasibility of mental health services being delivered to the community through the existing health care system (Wright, 1991)<sup>12</sup>. With the experiences of Lalitpur district, community mental health service were provided through the existing health care system in Morang District, eastern part of Nepal in 1991 by Mental Health Project, IOM and Mental Health program, UMN. Similarly the model was replicated in the western region of the country to provide mental health services from primary health care system.

The number of mental health professionals is grossly inadequate for the mental health needs of the country. There are 38 psychiatrists including foreign psychiatrists working in the country (29 Nepali + 9 foreigners), five clinical psychologists and 18 psychiatric nurses were serving in the field of mental health for more than 23 million people in the country (Data Bank, Mental health Project IOM, 2004). Unfortunately, psychiatric social workers and occupational therapists are not even available in the country as they could play significant role in the rehabilitation of mentally ill patient. Of the aforementioned trained manpower, majority are situated and employed in the capital city, Kathmandu. Therefore, there is an increased challenge in the delivery of mental health service because of lack of mental health trained manpower. The lack of supply of mental health drugs due to exclusion on the essential drug list by the government, lack of mental health policy and law in the country and common stigma against mental illness in the community due to poor awareness, were also equally experienced as major limitations to development of mental health services. The only feasible option is to provide mental health services at grass root level through integration within the existing health care systems. Empowering health staff in mental health through training, supervision and supply of mental health drugs is necessary to ensure quality and sustainability of the service.

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<sup>12</sup> *ibid*



## 1.4 Western Region Community Mental Health Program

Mental Health Project (IOM) and Mental Health Program (UMN) jointly started the community mental health program in the western region of Nepal since 1992, with the earlier experiences of running similar program in central (Lalitpur) and eastern (Morang) Nepal. This program was named WRCMHP. The program was developed into four phases, the first three have been completed. At present fourth and final phase is in progress. The main aim of this program is to integrate mental health services into existing health care system, providing a viable model for government to replicate and implement throughout the country. The first phase was called District Community Mental Health Program Kaski (1992-1993). It carried out mental health activities in only one district (Kaski) during this period. The program carried out following activities: training of health workers, provision of patient record cards, follow-up sheets, essential drugs to health posts, provision of different mental health educational materials for health post staff and community people and supervision and referral services. In the second phase (1993-1996) community mental health services were extended to Syangja district. During this time a training base office was established in Pokhara to continue training and supervision activities.

Training activities were also extended to grass root level community resources such as traditional healers, schoolteachers and police. This training was especially on raising awareness of mental health issues among the public. The third phase started from 1996/97-2000. The community mental health program was further extended into four districts including Baglung, Tanahun, Nawalparasi and Rupendehi. Similar activities were continued as in the second phase of the program (Adhikari et al, 2000a). The fourth or final phase started during the period of 2001-2004 where community mental health program has been further extended into another five other districts of the western region including Kapilbastu, Gulmi, Parbat, Palpa and Gorkha in selected PHC or Health Post (Annual Report of WRCMHP, 2001/2002).

Western region community mental health program used the following approaches:

- Mental health block training; 10 days training for healthworkers of primary health center and health post
- Service delivery from health post, primary health care center and district hospital by the trained healthworkers.
- Clinical Supervision by the psychiatrist
- Awareness program at local level such as training to traditional healers, teachers, female health volunteer etc.

WRCMHP has used following mode of implementation:

- Satellite clinic runs every month in the selected health post and primary health center.
- Support to Community Drug Schemes (CDP) for mental health drugs from WRCMHP.
- Clinical and managerial supervision from psychiatrist and mental health supervisor.



- Mental health education to public to create awareness regarding mental health issues.

The above mentioned approach and mode of implementation were reflected in the implementation of program activities. Nearing the conclusion of fourth phase of the community mental health program, mental health services were being provided from following health posts or primary health care centers of different districts in the western region (Satellite Clinic Roster-WRCMHP, 2003 / 04).

District	Health facilities
Kaski	Deurali healthpost
Syangja	Walling PHC
Tanahun	Dumkouli Hospital
Nawalparasi	Dumkouli PHC
Rupendehi	Lumbini PHC
Kapilbastu	Pakadi HP
Palpa	Khasouli PHC
Gulmi	Johang PHC
Parbat	Hospital / Tilahar HP
Baglung	Hospital
Gorkha	Bungkot HP

Monthly satellite clinics and supervision were running more regularly from the central and the regional office of the WRCMHP to reinforce and the support the integration of mental health services into the existing health care facilities.

This clearly highlighted the need of mental health services at a grassroots level. This study is an attempt to evaluate the impact of community mental health service in the western region of Nepal.

## 2.0 Aim and objectives of the study

### 2.1 Aim of the study

To study the impact of community mental health programs in the western region of Nepal run by mental Health Project, IOM in partnership with Mental Health Program, UMN.

### 2.2 Objectives of the study

- To assess the impact of training and supervision in mental health in the area of knowledge, attitude and practices of trained health workers in the western region.
- To assess the effectiveness of community mental health services provided from health post and primary health center in the western region.
- To assess the knowledge and attitudes of community people in the western region in area of mental health.



### 3.0 Literature Review

Available literature in the area of impact studies of community mental health programs is scarce. In addition it is very difficult to get relevant literature to Nepal because there have only been a few studies completed to this topic. It is equally difficult to find international literature on this topic, particularly in the area of evaluation and outcome studies of community mental health programs. However it does not mean that there are no or few community mental health programs other countries of the world. The lack of publication of such work or lack of access to such materials might be the prominent reason. Literature regarding the prevalence of mental health problems in different categories of population both within Nepal and other countries is accessible. This information is not relevant to the current study. Some of the available literatures relevant to current study are highlighted below.

#### **Wright (1991):**

Wright's study (1991) entitled 'Five years of Community Mental Health Services; an Evaluation Report' evaluated the first community mental health program in the country. She evaluated five community mental health services within CDHP health post in Lalitpur district. The study has established seven objectives and evaluated mental health services in regards to utilization of services, socio-demographic detail of mental patients attending health post, information on diagnosis, community awareness, healthworkers knowledge, attitude and practices, cost of the program and usage of program as a demonstration model of a community mental health service.

Semi-structure questionnaires for health post staff were used to assess attitude in community mental health. Individual interviews were carried out to evaluate attitudes of both the community and the health post staff. Patient records and reports were evaluated to assess the community service from patient perspectives.

Result of the study showed more female patients (56%) were treated than male. 16% of patients were children and majority belonged to age range of 16-25 years (32%). Epilepsy (30%) and depression (33%) were major mental health problems as 63% of cases comprised of these two disorders in health post. There are sex ratio differences in the case of depression, as more female were found to have depression than male. It could be due to increased awareness and competency of health workers to pick up of the condition. More than fifty percent patients had been ill for more than one year. A similar amount of patients had traveled more than one hour to attend health post. Majority of the patients (63%) sought out traditional healer treatment before they attended the health post. 68% patient records showed that health workers gave follow up advice. Majority of the staff were satisfied with the mental health service in the health post even though it had increased workload.

Health staff and community people both suggested regular mental health services with regular supply of medicine, training to all health staff, supervision from specialist, counseling training, integration of mental health services with general health services and inclusion of mental health contents in all health courses and high school courses.



Supervision input differed on the distance of the healthpost from available supervisors. More supervision occurred in the closer health posts to the regional office and where the mental health supervisors were based. Community people could recognize epilepsy and mental retardation more frequently than other conditions. They attributed causative factors for mental illness to inadequate diet, mental weakness or brokenness, physical causes, worries and witchcrafts etc. There was a low level of awareness in the community particularly in relation to depression.

In her recommendation Wright mentioned that health post staff were capable to provide mental health service. She further highlighted the need for training to all health staff, regular supply of drugs and for supervision to occur, as these factors are highly mandatory for the sustainability of the program. Some of the difficulties she found while in health post were poor record keeping, referral rate to specialist too low, low dose of medicine prescription (epilepsy and psychosis). She also recommended that community mental health service provided in CDHP Lalitpur offered a workable model of Community Mental Health Services that can be replicated, with modification, to other areas of the country.

The information within this study was primarily obtained from health staff of health post, village health committee members, traditional healers and traditional birth attendants with a small sample of population. There is no control group in the sample to compare the findings with in an area where no service provided. Similarly, the effect of the community mental health services were not evaluated from patient, patient relatives and the community perspectives which could indicate an accurate impact of the awareness program and mental health services.

In another study, (Jackson et al, 1993) evaluated the effect of "New Community Mental Health Based in Primary Care" in South Manchester. A team of mental health professionals were involved in the identification and intervention at different levels. The involvement of such a team approach in mental health services have been designed to bring the change to the in-patient treatment of mental patients. There was a control group to compare the findings of the index groups within the study. Index group had a larger population than the control group. The population selected for the study had wide range of age distribution (17-64 years). The data was analysed with the use of SPSS with the confidence interval analysis.

Findings revealed that admission rate of mental patient into the in-patient service decreased when the new community mental health team started serving in a coordinated way. In the beginning, both the index group and the control group, experienced a lack of cooperation among the different level of manpower such as GP doctors, and the other mental health teams (Psychiatrist, Psychologist, Psychiatric Nurses, Social workers, Occupational Therapists). It also evaluated the prevalence and inception rates and the effectiveness of the services provided by the new mental health team. Findings of the study had been compared with the previous study, which were matched positively.



**Adhikari et al. (2000a,b)**

Adhikari et al. (2000a) Conducted a community survey study to evaluate nonpsychotic mental distress in one of the villages of Tarai district (Rupendehi) of western region. The study population was selected following census method among the total population of three wards of a VDC chosen purposively. SRQ was the main instrument used for prevalence study. 414 adults above 16 years were interviewed. The total point prevalence rate was 13.1% in total. Female had a higher prevalence rate than male.

This study also collected attitudes of community people regarding mental health. Results revealed that community people defined mental health as free from disease. Community people had experiences with mentally ill patients having psychosis, epilepsy and depression. Family problems, alcohol, husband second marriage and economic problems were the causes of mental illness, mentioned by the community people in focus group discussions. Regarding the recommendation to health post services, supervision and improved management of administration were suggested.

In addition, this study aimed to increase available information regarding the prevalence of mental health problems in the country. However, there was confusion in the analysis of the data, particularly in selecting the analytical tools of the data because Chi square test is not generally used to prove whether a difference in two groups is significant or not. Similarly, there is no comparative group to compare the attitude related information. Confusion regarding the sampling technique was also seen as the author refuted census method as the most scientific method of data collection. Random sampling techniques are often used in research because it is difficult to cover a whole population. It is more time and economically viable than any other sampling method.

Adhikari (2000b) has done another study in Myagdi on mental health awareness using focus group approach. Data were collected mainly through focus group discussions. The details of the focus group discussion sample population were not explained in this study. However, the discussion had been carried out among female community health volunteers, traditional healers, fathers groups, hospital support committees, mothers groups, student of secondary level and school teachers as a target population of an awareness raising program in mental health. Nine different focus group discussions were carried out. Discussion were concentrated on the area of concept of health, mental health, experience with mentally ill patients, causes of mental illness, behavior towards mental illness, treatment of mental illness and role and responsibilities of family towards mental patients.

Majority of the groups knew about how to be healthy and the definition of health. Educated people such as the students, teachers and hospital support committees knew about the definition of health. Majority of the participants had less awareness on mental health. Traditional healer's explanations regarding the causation of mental illness involved physical, psychosocial and traditional beliefs e.g. dissatisfaction with life, family problems, heredity, high blood pressure, sin or ghost. Traditional healers were in favor of using modern health services in the health post or hospital, as they had referred



patients after they completed their healing rituals. Mothers and FCHV groups highlighted psycho-social factors e.g. worry, sexual harassment, physical illness, poverty, alcoholism as causes of mental illness with respect to women. Cultural restriction and patriarch society imposed large amounts of stress upon the females and have demanded women take many different roles within the society at the same time. It was significant issue regarding the causation of mental illness among the female groups. Participants of the focus group discussion could identify psychosis (*boulaha*), epilepsy and mental retardation.

It is helpful to have information on mental health from different perspective before mental health activities are planned, thus we can understand the needs of the community and develop programs accordingly. The study was carried out to get feasibility information and public attitude about the reception of a mental health service. The sampling framework and methodology was ambiguous. There is no information provided from the community who were using mental health services so that information could be compared in both situations. Similarly the qualitative analysis is mainly involved to describe the response obtained from various participants. It has not followed strict scientific methods in conceptualization of qualitative information.

**Isaac, M.K. & Sinha, R.N. (1996)**

In their evaluation report of western region community mental health services, the impact of the community mental health program in two districts (Kaski and Syangja) found effective from various aspects such as knowledge of trained health staff in mental health, community and patient attitude towards mental health services. They had taken references of the pre-post training questionnaire scores from the participants of one group of training. Post test score exceeded very high with the pretest score. The interview information from the participants of the mental health block training also revealed good interest for the training and were aware about the usefulness and need of the mental health services in the community where they were providing service. Almost all the participants were enthusiastic to start mental health service in their respective health institutions. Similarly, community interview and mental patient interview information also emphasized on the need and importance of mental health services in their community. Community mental health service found to be effective and suggested to extend to other district as well in western region of Nepal.

The methodology used had limitation due to the lack of scientific tools to collect informations. Observation of the activities, interview and study of earlier report of the program were major tools used for the study. It has no comparative group to compare the effectiveness of the community mental health services at the same time. The study mainly aimed to evaluate the effectiveness of the program, so, the methodology might be adequate to answer the chosen objectives of the study.



**Braganza, D & Nap T. H. (1999)**

In the short evaluation, completed by Braganza and Nap (1999) of the Mental Health Program, United Mission to Nepal, the western region community mental health program was also evaluated. Open interview, group discussion and studies of documents were the key methodologies followed for the study. The evaluation focused on training, service delivery and the functioning of the Pokhara Office. They found training component highly effective as their interview with health workers showed that they were able to identify and treat majority of mental cases in the health post. Some of them were also serving mental health patients at the clinics. Though they attempted to interview the traditional healers, they were unable to. Their brief interview with FCHV's, revealed that women were also encouraged to have input in mental health so that they can refer such cases to health post.

In the evaluation of service delivery, they commented it was poor, as there was no increase in patient flow in health post even though mental health service started five years ago in the health post they visited. On the basis of their observation of service delivery, in few areas of the western region, they concluded that it was not effective and recommended not to expand it. Their suggestion was critical and based on either bias or they lost motivation to observe many health facilities where mental health services were available. Obviously, any program could not run at a desired level of success in all parts. Difficulty in service delivery meant that some centers could not represent the service of all the service delivery points, which was not appreciated while giving recommendations.

Some of the key concerns raised by the evaluators were for better implementation of the community mental health program. In particular, the issue raised included supervision, coordination with HMG at district, regional and central level, and recording of cases and defaulter cases.

This evaluation report obviously lacks information from the grass roots such as traditional healers, teachers, female community health volunteers and others. The evaluators also acknowledged this limitation. It can not be considered as a scientific study due to methodological limitation.

**Nakarmi, B. (2004)**

Nakarmi (2004), completed an assessment study on the quality of mental health service provided by the CDHP supported healthpost in Chapagaon. The information used to assess the quality of mental health services obtaining from trained health staff, their knowledge, attitudes and practices in mental health. Information was also collected from traditional healers trained in mental health in the area of knowledge and attitudes in mental health and finally information was taken from the health post records of mentally ill patients. A cross sectional study design was used for the study and followed both quantitative and qualitative approaches to analyze the information.

Ten health staff, three focus group discussions of traditional healers and 15 case records of mentally ill patients from health post were the sample population of this study. Semi



structured questionnaire were used for health staff and traditional healers. Patient records were analyzed separately to see the quality of recording of mental patients. Findings revealed that the health workers (HA, CMA) were able to identify and treat epilepsy, depression and psychosis effectively from health post. ANMs were also able to identify and give needful health education and referral information to such patients and the community. In the study of impact of mental health services, healthworkers replied that mental health training to health staff, regular mental health clinic, improved skills in record keeping and improved community participation were major achievements.

The health staff were aware regarding the benefits of a recording system in mental health. Records of fifteen mentally ill patients were analyzed in three different areas such as drug intake, follow up details and drug dispensary. Information on these three areas were further categorized into sections -recorded, partial recorded and not recorded. Findings revealed that more than 80% cases of mental patient's information was recorded adequately in all three conditions. Similarly, focus group discussions of traditional healers reflected that they were aware on concepts, causes, and their role in the mental patient.

This study obviously included small sample from only two health posts of Lalitpur District. Furthermore, patient records were limited as only from one health post were included in the study. The other limitation of the study involves the methodology, the study attempted to seek information from only three different categories of mental patients (Epilepsy, Depression and Psychosis) but not other mental illnesses. Similarly, there is no control group to compare the findings so that it can reflect the impact of the mental health program clearly. Limitations also exist in the selection tools and their use observed from the main text of findings.

Considering the available literature current study attempted to have information from both experimental and control groups of sample, and attempted to reduce the bias and other possible limitations as discussed in the literature review. The information available from the two groups was also compared.

## **4.0 Methodology of the study**

### **4.1 Statement of the problems**

- Whether mental health service can be delivered from the existing health care system (i.e. is it possible to integrate mental health service)?
- Whether mental health service provided from primary health care system is effective?
- Whether there is any change in public attitudes to mental health in western region of Nepal where community mental health service is available?
- Whether there is change in perception towards mental health services in mental patients and their relatives in western region where community mental health service is available?

### **4.2 Design of the study**

It is a qualitative study to explore the impact of community mental health program through the use of standard techniques. Experimental-control design was used to compare the impact of the community mental health program.

### **4.3 Sampling technique and sample size**

Two groups of the sample, experimental and control were selected from seven districts of western region of Nepal. The experimental sample populations were taken from five districts of the western region where community mental health programs were running. Two districts comprised the control group, which was selected purposively. Consideration was given to the distance when selecting the district for control population. It was assumed that the control group had no effect on the mental health services where it was available. Samples were taken from three clusters such as health post staff, community people and patient who were receiving treatment from the health post. The details of the sample population were provided below in the flow chart.

#### **4.3.1 Health staff**

Twenty-seven health post staff, which were trained and providing mental health services were interviewed from five districts (Kaski, Syangja, Tanahu, Nawalparasi and Rupendehi) in the study group. Eleven trained health staff were taken from each Kaski and Syangja district purposively, because of the full coverage of the program. Three health staff from Tanahu (Damauli hospital), one from Nawalparasi (Dumkouli PHC) and one from Rupendehi (Lumbini PHC) were interviewed respectively. This included all trained staff of these three districts. Similarly, for the control group three health post staff from another health post of Tanahu district were taken as a control for Damauli hospital, one health-staff from other than mental health service provided health post each Nawalparasi and Rupendehi district had been interviewed as control group for Dumkouli and Lumbini PHC respectively. Eleven health staff from Palpa and ten health staff from



Kapilbastu were interviewed as control group sample for health staff of Syangja and Kaski districts respectively.

### 4.3.2 Community people

Ten-community focus groups comprising five groups from the control areas and five groups from the experimental areas were interviewed. In each group there were ten participants, five male and female selected purposively. They were local people who often visited the health post or health center for their various health problems. They were the community of the area served by the health post or health center. The community focus groups did not include any teachers, female community health volunteers (FCHV), traditional healers or local leaders because they were directly benefiting from the WRCMHP, as they were the key target group in mental health orientation training to disseminate mental health awareness among the public. This study intends to evaluate the level of awareness in mental health among the local people who received mental health information from local resources whom WRCMP oriented in mental health.

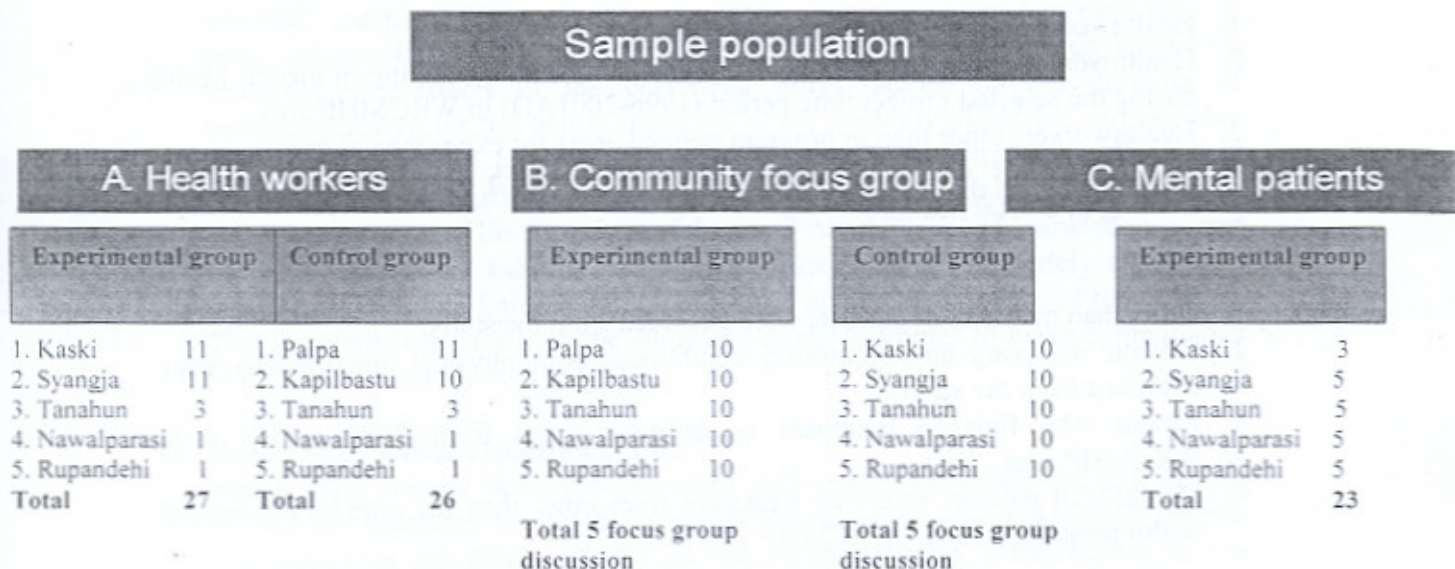
### 4.3.3 Patient sample

Twenty-three mentally ill patients were selected for interview from the areas where mental health service were available to the public. The selection process followed simple random techniques from the health post records of mental health clinic. Every third number in the registration was included in the study. The number three was used when patient were less than 15-20 in the day of data collection but it was not applied for Kaski district where insufficient patient were available at the time of the study. The research proposal stated an intention to interview five mentally ill patients who received treatment from the health post in the selected five districts so that the total number interviewed would be 25 (mentally ill patients). Unfortunately, only three patients were available from Kaski district. There were expected numbers of patient in other health post from four districts (i.e. five from each health post of the districts selected randomly)

There were no patient samples in the control group because there were no mental health services available. Hence they did not treat the mental ill patients but may have referred to other centers where mental health service were available.

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#### 4.3.4 Sample flow chart



#### 4.3.5 Sample selection criteria

##### Inclusion criteria

###### Healthworkers

1. Health Assistance (HA), Senior Auxiliary Health Worker (S.AHW) and Auxiliary Health Workers (AHW) were selected for this study from PHC and HP where WRCMHP implements mental health activities.
2. Health workers who had received 10 days block training in mental health were selected for the study.
3. Health workers involved directly in providing mental health services after training for at least one year were selected in the study.

###### Patient sample

1. Mentally ill patients diagnosed and treated from PHC or HP of western region where community mental health service was available.
2. Patients receiving regular treatment for mental illness from PHC or HP where community mental health service was available at the time of study.

###### Community people sample

1. Local community members and relatives of mentally ill patients.
2. Community people who use community health services regularly.

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## **Exclusion criteria**

### **Healthworkers**

1. Healthworkers who had not received training in mental health.
2. Healthworkers serving less than one year after receiving training in mental health during the selected project time period (1996-2001AD) in WRCMHP area.
3. Healthworkers other than in program defined areas for experimental group
4. Health workers who did not provide mental health services after receiving training in mental health.

### **Patient**

1. Other than mentally ill patients were excluded from the study.
2. Patients suffering any co-morbid conditions (both physical and mental) were excluded from the study.
3. Patient who finished treatment or defaulter cases from PHC or HP from WRCMHP area.
4. Mentally ill patients receiving treatment from other than the community mental health program through WRCMHP.

### **Community Sample**

1. Local leaders, FCHV, TBA, traditional healers, schoolteachers and children were excluded from the study.

## **4.4 Instrument of the study**

### **1. Identification information sheet for healthworkers:**

It seeks socio-demographic information such as name, age, sex, caste, education, marital status, religion, and work experiences etc. It was used both the control and experimental group population.

### **2. Mental health training evaluation questionnaire:**

It has been used for health staff in both the experimental and control group, to assess their level of knowledge in basic mental health. The community mental health program has used this form for pre test and post test evaluation in all mental health training conducted. It was developed by the Mental Health Program, UMN and Mental Health Project, IOM by a group expert in mental health. It has been extensively used in mental health, as the items of the questionnaire are easy to understand and can assess the basic knowledge of the participant. The questionnaire includes forty different statements in mental health, they can be rated either yes or no in the given box on the right side of each question.

### **3. Case report evaluation form:**

The case report evaluation form is also used to test the health worker's knowledge in mental health. Six different types of mental illness case descriptions are provided and nine different questions are asked that are related to each case. It seeks information on diagnosis, information to support the chosen diagnosis, treatment, side-effects of the prescribed drugs, advice on the duration of treatment, advice for the family members of the mentally ill patient and possible prognosis. This form has been used in all mental health training delivered to health staff by the western region community program and all other mental health training conducted. This form is useful to evaluate the level of knowledge gained by the trainees from the training. It is also used and tested widely among the health staff of South Lalitpur, Morang, Banke, and western region of the country. This form was used for both the study and control samples to make comparisons of the results between two groups.

### **4. Health staff attitude questionnaire:**

Health staff attitude questionnaire seeks information regarding the attitudes of trained and untrained health staff towards mental health and mentally ill people. The questions are related to the mental health training, effectiveness of the training in their daily work, effect of mental health service to the local community when such service was provided from the health post, community attitudes to mental health services and difficulties they may encounter while delivering mental health services in the health post. This questionnaire also includes questions related to the need of supervision and ways of enhancing skills in mental health, the process of integration of mental health into existing health care system, record keeping and the need of mental health service in health post. The questionnaire supplied is different for the control and study group. The former has only nine questions while the later has 11 questions because these questions were included to draw on working experiences in mental health.

### **5. Questionnaire for focus group study of community people:**

Research has developed this questionnaire. It is based on the course content of awareness raising programs completed by the western region community mental health program for local community people such as FCHV, traditional healers and schoolteachers. There are ten questions regarding knowledge in mental health including concepts of health, mental health, causes of mental illness, behavior towards mentally ill people by the community, ways to improve support of mentally ill and their family etc. Some questions were taken from an earlier study carried out by mental health program. The questions were asked in a group of selected local people and their knowledge and attitudes discussed.

### **6. Patient and relative interview form:**

This is also a self-developed assessment form to interview mentally ill patients treated at primary health care centers and health posts. It has two parts, form A and form B. Form A yields information from mentally ill patients regarding their experiences about the mental health services provided from the health post and



primary health care centers. Form B yields information regarding the experiences and impressions from relatives of mentally ill patients about mental health services provided from health posts and primary health care centers. There were nineteen questions for mentally ill patient and five questions for the relatives of mentally ill patients.

#### **7. Patient examination record form:**

The patient examination record form was developed for use by the psychiatrist who evaluates the selected mentally ill patients receiving treatment from the health posts or primary health centers. This evaluation tool focuses on four areas such as the reason for consulting the mental health clinic, diagnosis made from the treatment center (i.e. health post or primary health center), treatment given from the health post and the remarks of the psychiatrist regarding the diagnosis and treatment provided by the health post.

### **4.5 Procedure of the study**

Confidentiality and permission for the study was obtained from the relevant authorities and the participants of the study for ethical respect. Individual interviews were performed with the selected health staff following completion of the structured research questionnaire to assess the level of knowledge and skills in mental health practice. Four different sets of questionnaires were given to complete. They were the identification information sheet, the mental health training evaluation questionnaire, the case report evaluation form and the health staff attitude questionnaire. The research team explained every question, if they were not clear. The case report evaluation form took the longest for health staff to complete. It was particularly difficult for the control group because they were not trained in the content. However, the trained group also felt it to be difficult, as they had to remember their training knowledge and relate it to their experiences.

Information from the community participants was obtained through focus group discussions. The discussions were moderated by the research team focusing on the area of awareness on mental health as an impact of the mental health services made available in the community. Attitudes to health post services and mental health services (particularly if provided by the health post). All the participants were given equal chance to express their view. In some places where language became difficult (particularly in Tarai district) help was taken from the health post staff working in administration (i.e. no health background) or community people who could translate correctly for both parties. The information was recorded in tape for later detailed analysis.

Selected mentally ill patients were interviewed by the research team. Interview with the mentally ill patient were carried out individually focusing on their perception of mental health services in the community such as service accessibility and availability, time they have to spend to meet and consult with health staff, precision and clarity of the information provided by the health staff about their problems, advice and



recommendations such as how to take medicines, their possible side effects, approximate duration of medication, need of regular follow up, family role in the treatment and rehabilitation and how much information and queries about mental illness of the relatives of such patient were handled satisfactorily by the health post staff. Information was written in the questionnaires at the same time. Treatment information and record keeping of the treatment were also observed by the research team to obtain detailed information about the treatment such as name of the drug, dose, advice given etc.

The psychiatrist evaluated the selected mentally ill patients and made remarks regarding diagnosis and treatment provided by the health post. The information were documented in the patient evaluation form separately for each patient.

#### **4.6 Data Analysis**

Attitude and knowledge related questionnaires were analyzed following qualitative techniques. Information from health staff, patients and their relatives were coded, categorized, read overview, read line-by-line, marked word and sentences for condensation of information. The condensed information was then re-contextualized (developed description and concepts) and comparisons were made between the description and the raw data. Finally the concepts were compared between the two groups. Information from community focus group discussions were transcribed from cassette records, read and translated into English. The translated materials were transcribed from the cassette records, read and translated into English. The translated materials were then processed following the techniques as mentioned above. Such information were also compared and correlated with the information provided by health staff and community. Information obtained from the psychiatrist consultants were compared with the health staff information and significance analyzed. Computer software SPSS (Statistical packages for social science) was used for significance analysis.



## 5. Results of the Study

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## 5.0 Socio-demographic variables of health workers:

Information regarding sex, age, education, caste, religion, location of health centers, training, work experience and duration of training were presented in tabular form or graphs to make them understandable.

**Table 1**

			Experimental Vs. Control		Total
			Control group	Study group	
Sex	Male	N	22	24	46
		%	41.5%	45.3%	86.8%
	Female	N	4	3	7
		%	7.5%	5.7%	13.2%
Total	N		26	27	53
	%		49.1%	50.9%	100.0%

Gender distribution of the selected health workers showed male predominance in the result as 86.8% male and only 13.2% female. In total 53 samples of health workers were taken including control and study group.

**Table 2**

**Experimental Vs. Control \* Education Crosstabulation**

			Education			Total
			Below SLC	SLC	Higher Education	
Experimental Vs. Control	Control group	N	1	9	16	26
		%	1.9%	17.0%	30.2%	49.1%
	Study group	N		12	15	27
		%		22.6%	28.3%	50.9%
Total	N		1	21	31	53
	%		1.9%	39.6%	58.5%	100.0%

Tables 2 showed majority of the participants (58.5%) were belonged to higher education. In control group they were more than the study group. Table 3 below depicts the different level of higher education.



**Table 3****Experimental Vs. Control \* Higher Education Crosstabulation**

			Higher Education			Total
			Intermediate	Bachelor	Master	
Experimental Vs. Control	Control group	N	8	5	2	15
		%	26.7%	16.7%	6.7%	50.0%
	Study group	N	9	5	1	15
		%	30.0%	16.7%	3.3%	50.0%
Total	N	17	10	3	30	
	%	56.7%	33.3%	10.0%	100.0%	

Only 30 participants had higher education out of total sample (53). Intermediate level has the highest distribution. Equal percentages of cases were seen in both conditions i.e. control and study.

**Table 4 Professional education**

			Experimental Vs. Control		Total
			Control group	Study group	
Professional Education	AHW	N	17	14	31
		%	32.1%	26.4%	58.5%
	HA	N	8	13	21
		%	15.1%	24.5%	39.6%
	Public Health Supervisor	N	1		1
		%	1.9%		1.9%
Total	N	26	27	53	
	%	49.1%	50.9%	100.0%	

AHW has the highest distribution (58.5%) among three major categories.

**Table 5 Religion**

			Experimental Vs. Control		Total
			Control group	Study group	
Religion	Hindu	N	26	27	53
		%	49.1%	50.9%	100.0%
Total	N	26	27	53	
	%	49.1%	50.9%	100.0%	

All the health worker participants were belonged to Hindu religion.

Table 6

## Caste \* Experimental Vs. Control Crosstabulation

			Experimental Vs. Control		Total
			Control group	Study group	
Caste	Brahmin	Count	14	17	31
		% of Total	26.4%	32.1%	58.5%
	Chhetri	Count	4	5	9
		% of Total	7.5%	9.4%	17.0%
	Thanru	Count	1		1
		% of Total	1.9%		1.9%
	Magar	Count	1	1	2
		% of Total	1.9%	1.9%	3.8%
	Newar	Count	4	3	7
		% of Total	7.5%	5.7%	13.2%
	Thakur	Count		1	1
		% of Total		1.9%	1.9%
	Others	Count	2		2
		% of Total	3.8%		3.8%
Total		Count	26	27	53
		% of Total	49.1%	50.9%	100.0%

Caste distribution of health workers showed that Brahmin has the highest distribution followed by Chhetri and Newar respectively.

Table 7

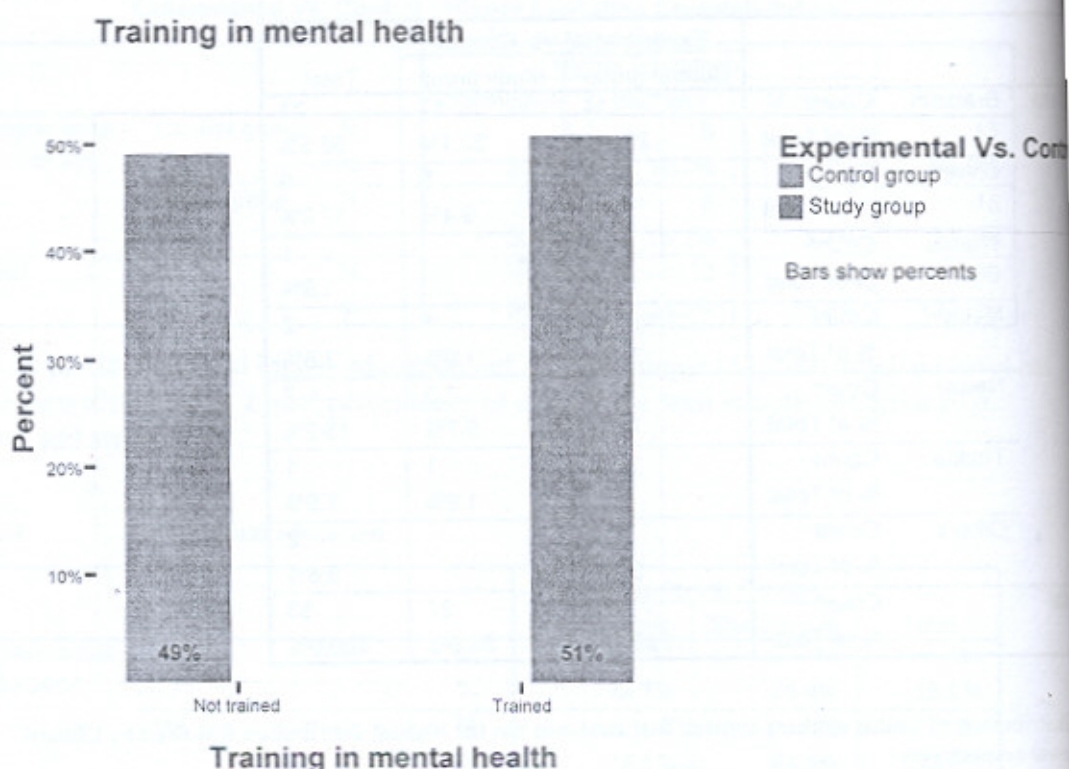
## Experimental Vs. Control \* Type of mental health training Crosstabulation

				Type of mental health training	Total
				Block training	
Experimental Vs. Control	Study group	N		27	27
		%		100.0%	100.0%
Total		N		27	27
		%		100.0%	100.0%

This table revealed all the participants of study group received mental health block training. Control group did not have received this training, so they were not included in the result above.



Figure 1



The figure shows that 49% health workers were not trained in mental health who comprised control group for this study.

Table 8

VDC/Municipality \* Experimental Vs. Control Crosstabulation

			Experimental Vs. Control		Total
			Control group	Study group	
VDC/Municipality	Municipality	Count	4	17	21
		% of Total	8.7%	37.0%	45.7%
	VDC	Count	16	9	25
		% of Total	34.8%	19.6%	54.3%
Total		Count	20	26	46
		% of Total	43.5%	56.5%	100.0%

Location of health facilities showed that 54% were located in VDC in total. However, more health centers (37%) were located in municipality for study group than control group.

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Table 9

## Means

Experimental Vs. Control		Age	Work Experience in month	Duration of training in days	Total scores of Case study form	Total of prepost test questionnaire
Control group	Mean	33.42	104.29		17.35	24.27
	N	24	24		26	26
	Std. Deviation	8.52	101.62		9.93	4.06
Study group	Mean	39.22	199.56	11.96	71.11	33.04
	N	27	27	27	27	27
	Std. Deviation	8.57	85.06	5.42	17.72	4.27
Total	Mean	36.49	154.73	11.96	44.74	28.74
	N	51	51	27	53	53
	Std. Deviation	8.95	104.01	5.42	30.67	6.05

Means of the age, work experience, duration of training, total scores of pre test, post test and total scores of case study have been shown in both control and study group. Control group did not have mental health training, so the figure is lacking in the respective box. There is obvious difference in the means of age, work experience, total scores of pre test, post test and case scores. The significance of the difference has been shown below another table.

Table 10

## ANOVA Table

			Sum of Squares	df	Mean Square	F	Sig.
Age * Experimental Vs. Control	Between Groups	(Combined)	428.245	1	428.245	5.867	.019
	Within Groups		3576.500	49	72.990		
	Total		4004.745	50			
Work Experience * Experimental Vs. Control	Between Groups	(Combined)	115308.5	1	115309	13.274	.001
	Within Groups		425641.6	49	8686.56		
	Total		540950.2	50			
Duration of training * Control	Between Groups	(Combined)	.000	1	.000	.000	1.000
	Within Groups		764.963	25	30.599		
	Total		764.963	26			
Total scores of Case study * Experimental Vs. Control	Between Groups	(Combined)	38287.75	1	38287.8	183.8	.000
	Within Groups		10626.55	51	208.364		
	Total		48914.30	52			
Total of prepost test questionnaire * Experimental Vs. Control	Between Groups	(Combined)	1018.224	1	1018.22	58.738	.000
	Within Groups		884.078	51	17.335		
	Total		1902.302	52			



Above result indicates the significant differences of mean in two conditions. Totals pre test post test scores and case scores differed significantly, which indicates the effect of mental health training to study group. The low mean scores in control group is because they did not get mental health training. The difference is strongly significant ( $P=.000$ ).

Table 11

name of district \* Experimental Vs. Control Crosstabulation

			Experimental Vs. Control		Total
			Control group	Study group	
name of district	Kapilbastu	N	10		10
		%	18.9%		18.9%
	Kaski	N		11	11
		%		20.8%	20.8%
	Nawalparasi	N	1	1	2
		%	1.9%	1.9%	3.8%
	Palpa	N	11		11
		%	20.8%		20.8%
	Rupandehi	N	1	1	2
		%	1.9%	1.9%	3.8%
	Syangja	N		10	10
		%		18.9%	18.9%
	Tanahu	N	3	4	7
		%	5.7%	7.5%	13.2%
Total		N	26	27	53
		%	49.1%	50.9%	100.0%

Table 11 revealed simply district wise distribution of samples both in control and study group.

## 5.1 Patient sample descriptive result

Table 12

Descriptive Statistics

	N	Mean	Std. Deviation
Duration of illness before treating from HP in month	23	30.12	46.30
Duration of treatment from HP in month	23	24.35	26.13
Time to travel from home to HP in minutes	23	64.35	96.30
Duration of waiting in HP in First visit in hours	23	1.55	1.25
Patient age	23	30.09	16.87

This table revealed means of duration of illness when patient first time visit to health post, means of duration of taking treatment from health center or health post, distance of home to health centers and duration of waiting to meet health staff in first visit. The mean age of the patient also provided in the table.

Majority of the patient were married (65%) as shown in the table.

Table 13

Patient Sex

		Frequency	Percent
Valid	Female	14	60.9
	Male	9	39.1
	Total	23	100.0

The gender of patient and their frequency and percentages are presented in the table.

Table 14

Patient Education

		Frequency	Percent
Valid	0	10	43.5
	1	1	4.3
	2	4	17.4
	3	3	13.0
	4	3	13.0
	5	1	4.3
	7	1	4.3
	Total	23	100.0

Table showing distribution of patient education. Education ranged from illiterate to 7 class.

Table 15

Patient marriage

		Frequency	Percent
Valid	M	15	65.2
	UM	8	34.8
	Total	23	100.0

Table 16

Patient Occupation

		Frequency	Percent
Valid	Farmer	3	13.0
	House wife	11	47.8
	Service	2	8.7
	Student	6	26.1
	Unemployed	1	4.3
	Total	23	100.0

Patient occupation ranged from farmer to unemployed. Housewife has the highest frequency.

Table 17

Health post adress

		Frequency	Percent
Valid	Damauli	5	21.7
	Deurali	3	13.0
	Dumkauli	5	21.7
	Lumbini	5	21.7
	Walling	5	21.7
	Total	23	100.0

Table showing distribution of patient according to health facilities from different district. In Deurali health post it is not possible to get 5 cases of mental patients.



## 5.2 Result on qualitative information from patient

Table: 1 A

### Comparison of diagnosis made by health workers and psychiatrist

C.No.	Diagnosis from health workers	Diagnosis from psychiatrist
S1	Anxiety Neurosis	Anxiety Neurosis
S2	Acute psychosis	Alcohol induced psychotic disorder
S3	Recurrent Depression	Depression with prominent anxiety symptoms
S4	Epilepsy	Epilepsy
S5	Epilepsy	Epilepsy
S6	Epilepsy with Mental Retardation	Post Encephalitic Sequele
S7	Depression	Depression
S8	Depression	Depression
S9	Epilepsy	Epilepsy
S10	Epilepsy	Post Encephalitic Sequele
S11	Depressive disorder	Depressive disorder
S12	Epilepsy	Down's Syndrome, Mental Retardation, Epilepsy
S13	Depression Disorder Moderator	Depressive disorder-recurrent-Moderator
S14	Chronic Psychosis	Schizophrenia (Paranoid)
S15	Epilepsy	Epilepsy -generalized T/C
S16	Epilepsy	Seizure disorder, generalized T/C
S17	Depressive disorder	Depressive disorder severe with psychotic symptoms
S18	Depression	Depression
S19	Psychosis	Psychosis
S20	Epilepsy	Generalized Anxiety Disorder D/D Seizure Disorder
S21	Mixed Depressive disorder	Depression-improving gradually
S22	Depression	Depression with prominent anxiety symptoms
S23	Bipolar Affective Disorder	Functional psychosis

Table 1 B

### Agreement in diagnosis between health workers and psychiatrist

Evaluation	N	Percentage
Agreed	16	69.56
Partial Agreed	6	26.09
Not Agreed	1	4.35
Total	23	100.00

Almost 70 % diagnosis were agreed between the trained health workers and psychiatrist. Partial agreement refers to agreement of symptomatic diagnosis or differential diagnosis. The detail of diagnosis pattern in two categories is given in table 1A.

Table 1 C  
Diagnostic Comparison

Health worker			Psychiatrist		
Diagnosis	N	Percent	Diagnosis	N	Percent
Epilepsy	9	39.13	Epilepsy	5	21.74
Depression	9	39.13	Depression	9	39.12
Anxiety Neurosis	1	4.35	Anxiety neurosis	1	4.35
Psychosis	4	17.39	Psychosis	3	13.04
			Alcohol Ind. Psychosis	1	4.35
			Post encephalitic sequele	2	8.70
			Down's syndrome/ MR/ Epilepsy	1	4.35
			GAD, D/D -Seizure disorder	1	4.35
Total	23	100.00		23	100.00

The agreement in the diagnosis of depression, psychosis and anxiety neurosis between health workers and psychiatrist is almost cent percent. In epilepsy, four cases were partial agreed with psychiatrist diagnosis. In epilepsy the presenting complain were agreed in both groups, however, psychiatrist provided differential diagnosis as well.

Table 2 A  
Comparison of treatment made by health workers and psychiatrist

Code Number	Health workers	Psychiatrist
S1		Amitriptyline 25 mg daily
S2	CPZ 150 mg /day, Benzhexol 4 mg/day	Gradually reduce and stop CPZ
S3	Amitriptyline 50mg /day	Amitriptyline
S4	Phenobarbitone 60mg /day	Same continue
S5	Phenobarbitone	Same
S6	Sod. Valporate 600mg/day, CPZ 100mg/ day	Increased dose of Sod. Valporate up to 800mg daily, CPZ 75mg daily
S7	Amitriptyline	Amitriptyline 100mg daily
S8	Amitriptyline 75mg/day, Inderal	Same continue
S9	Phenobarbitone 60mg daily	Same continue
S10	Phenobarbitone 90mg daily	Phenobarbitone 120mg daily
S11	Amitriptyline 75mg / day	Amitriptyline 150mg daily, Propanolol 20mg daily
S12	Phenobarbitone 30mg/day, Phenytoin 100mg/day	Change medicine to Sod.Valporate 400mg /day, if fit is not controlled add Clobazam 5mg daily.
S13	Amitriptyline 25mg/ day	Amitriptyline 150mg daily
S14	CPZ 150mg /day, Benzhexol 4mg/daily	CPZ 150mg daily
S15	Phenobarbitone 60mg daily, Phenytoin 100mg daily	Stop Phenytoin, Increased Phenobarbitone up to 180mg daily
S16	Phenobarbitone 30 mg daily	Same continue
S17	Amitriptyline 75mg daily, Trazine Sc. 2.5mg daily	Amitriptyline 150mg daily, Stop Trazine Sc.
S18	Amitriptyline 25mg daily	Same continue
S19	CPZ	Same continue
S20	Phenobarbitone 60mg daily	Continue same
S21	Imipramine 25mg daily, Inderal 30mg daily, Cynocal 16mg daily	Continue Imipramine, Propanolol 40mg daily
S22	Imipramine 50mg daily	Continue same, Tricyclic antidepressant
S23	CPZ 100mg daily, Pacitane 2mg daily	Continue same



**Table 2 B Agreement in treatment between health workers and psychiatrist**

Evaluation	N	Percentage
Agreed	10	43.48
Partial Agreed	10	43.48
Not Agreed	2	8.69
Not clear	1	4.35
Total	23	100.00

**Table 3 Accompaniment in first visit**

Accompaniment	N	Percent
With Family	19	82.60
Self	2	8.70
With Neighbor	1	4.35
With relatives	1	4.35
Total	23	100

**Table 4 Referral source to mental health service in HP / PHC**

Source	N	Percentage
Relatives	3	13.04
Neighbors	7	30.43
HP staff	5	21.74
FCHV	2	8.70
Self	1	4.35
Polio field workers	1	4.35
From HP information board	3	13.04
Hospital	1	4.35
Total	23	100

**Table 5 Perception of Mental health service of HP from relatives**

Evaluation	N	Percentage
Not much	1	4.35
Good	4	17.39
Very good	9	39.13
Absent of relatives	9	39.13
Total	14*	100

**Table 6 Patient's satisfaction from health post service (Relatives)**

Evaluation	N	Percentage
Not satisfactory	0	0
Some what satisfactory	3	13.04
Satisfactory	14	60.87
Very much satisfactory	6	26.09
Total	23	100.00

**Table 7 Reluctance of patient to come HP/ PHC for treatment in the beginning (Relative)**

Evaluation	N	Percentage
Yes	0	0
No	14	60.86
Absent of relatives	9	39.14
Total	23	100.00

**Table 8 Understanding of problems by health workers (Patients)**

Evaluation	N	Percentage
Not understood	0	0
Understood well	22	95.65
Very much understood	1	4.35
Total	23	100.00

**Table 9 Prescribing medicine from health post**

Evaluation	N	Percentage
Yes	23	100
No	0	0
Total	23	100

**Table 10 Regular intake of medicine (patient)**

Evaluation	N	Percentage
Yes	20	87.96
Missing	3	13.04
Total	23	100.00

**Table 11**  
Health education on drugs from health workers (Patient)

Evaluation	N	Percentage
Yes	23	100
No	0	0
Total	23	100
Contents of information		
<ul style="list-style-type: none"> <li>• Take medicine at bed time</li> <li>• Take regular medicine</li> </ul>		

**Table 12**  
Information on S/E of drugs (Patient)

Evaluation	N	Percentage
Yes	19	82.6
No	4	17.4
Total	23	100.0
Contents		
<ul style="list-style-type: none"> <li>• Dryness of mouth and sedation</li> <li>• Drinks lots of liquids</li> </ul>		

**Table 13**  
Information about F/U (Patient)

Evaluation	N	Percentage
Yes	1	4.35
No	22	95.65
Total	23	100.0
Contents		
<ul style="list-style-type: none"> <li>• Monthly follow up.</li> </ul>		

**Table 14**  
Information on duration of drug use (Patient)

Evaluation	N	Percentage
Yes	15	65.22
No	8	34.78
Total	23	100.00

**Table 15**  
Progress information (Patient)

Progress	N	percentage
40-60 %	9	39.13
60-80 %	7	30.44
80-100 %	7	30.44
Total	23	100.00

Progress is measured on the area of presenting complain, work efficiency, family life, and social life.

**Table 16**  
Progress report from relatives

Progress	N	Percentage
40-60	5	21.7
60-80	5	21.7
80-100	13	56.6
Total	23	100.00

**Table 17**  
Discussion of problems with family by HW (Patient)

Evaluation	N	Percentage
Yes	17	73.9
No	6	26.1
Total	23	100

**Table 18 A:** Information from HW about role of family (Relative)

Evaluation	N	Percentage
Yes	8	34.8
No	4	17.4
Absent of relatives	11	47.8
Total	23	100

**Table 18 B:** Family role in treatment (Relatives)

- Supportive in taking care of medicine, regular follow up and in other areas.
- Family has an important role
- Show love, affection and no criticism.
- Provide help on time.
- Nine patients did not have relatives during the time of interview.

**Table 19**  
Suggestion given to mental health service (Patient and relatives)

- Free supply of medicine
- Adequate drug support
- Less waiting time to consult health workers
- Regular support
- Better to have all the service at HP
- Regular supervision
- Availability of mental health specialist
- No suggestions (11 participants)



There is significant level of agreement of treatment protocol between healthworkers and psychiatrist as revealed by table-2b where 44% treatment is agreed fully and similar percentages is agreed partially. The choice of treatment is same even in partial agreement protocol, though they were given in low dose. Table 3 revealed that almost 83% patient were visiting health facilities with family members. Most of the patient received information on mental health (Table 4) from neighbors (30%), followed by health post staff (22%) and relatives (13%) respectively. Only 61% patients were accompanied by their relatives at the time of evaluation for this study in health post (Table 5) out of which, 58.5% replied that mental health service at health post is satisfactory. When the same information is compared with patient receiving treatment (Table -6), 87% replied that service was satisfactory.

Regarding the reluctance shown by patient to go to health post for treatment (Table 7) all the patient party (61%) replied that patients were not reluctant for it. All except one patient (Table 8) accepted that healthworkers were efficient to understand their problems and give treatment. Like wise all patients received drug treatment (Table 9). Regarding the compliance of medicine prescription from health post, 88%(Table 10) told that they were taking medicine regularly. However, 13% patients were missing the dose due to various reasons (usually they forget). Almost all patient received health education (Table 11) on time about the need of compliance of treatment. They were mainly told to take medicine at be time, and take it regularly. Similarly, table 12 showed that 83% patient received information regarding the side effect of medicine given to them by healthworkers. Dryness of mouth and sedative effects of the drugs were told by the health workers. Drinking of plenty of liquids was suggested as remedy to reduce these effects.

Regarding the information on the need of follow up, 96% patient replied that they were told to visit monthly for follow up (Table 13). 65% patients were told that they were informed regarding the duration of treatment (Table 14) while remaining told that they did not know about it. 61% patient compliance (Table 15) that they felt better almost 60-100 % from the health post treatment. Progress was measured on the area of presenting complaints, working efficiency, family life and social life of the patient. The same informations when compared with patient relatives showed that even better out come such as 77% (Table 16) replied about 60 -100 % improvement.

Majority of healthworkers discussed the problem of mental patient with their family members available at the time of consultation (74%, Table 17). Table 18a and b presents the information regarding family role in treatment. Family support were measured in the area of regular medicine in take, follow up and taking care in food and hygiene. The need of emotional support is also explained to patient relatives. Regarding the suggestion given to the mental health service (Table 19) by the mental patients and their relatives, majority of them spelled out the need of supply of free mental health drugs from health post as like other general health problems and less of waiting time to meet the concerning healthworkers.

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### 5.3 Differences of paper case diagnosis profile between two groups

Table 20

Report

Diagnosis score

Experimental Vs. Control	Mean	N	Std. Deviation	Sum
Control group	1.88	26	1.21	49
Study group	5.52	27	.94	149
Total	3.74	53	2.12	198

This table revealed total scores of six cases diagnosed by health workers. Control group could get in total 49 scores with mean and standard deviation 1.88 and 1.21 respectively while experimental (study) group achieved 149 scores from six diagnosis cases provided with case story. The mean and standard deviation are 5.52 and .94 respectively. There is a difference between two means. The significance is analyzed and report is presented below. It indicates that trained health workers are significantly different in capacity of diagnosing the cases than the untrained one.

Table 21

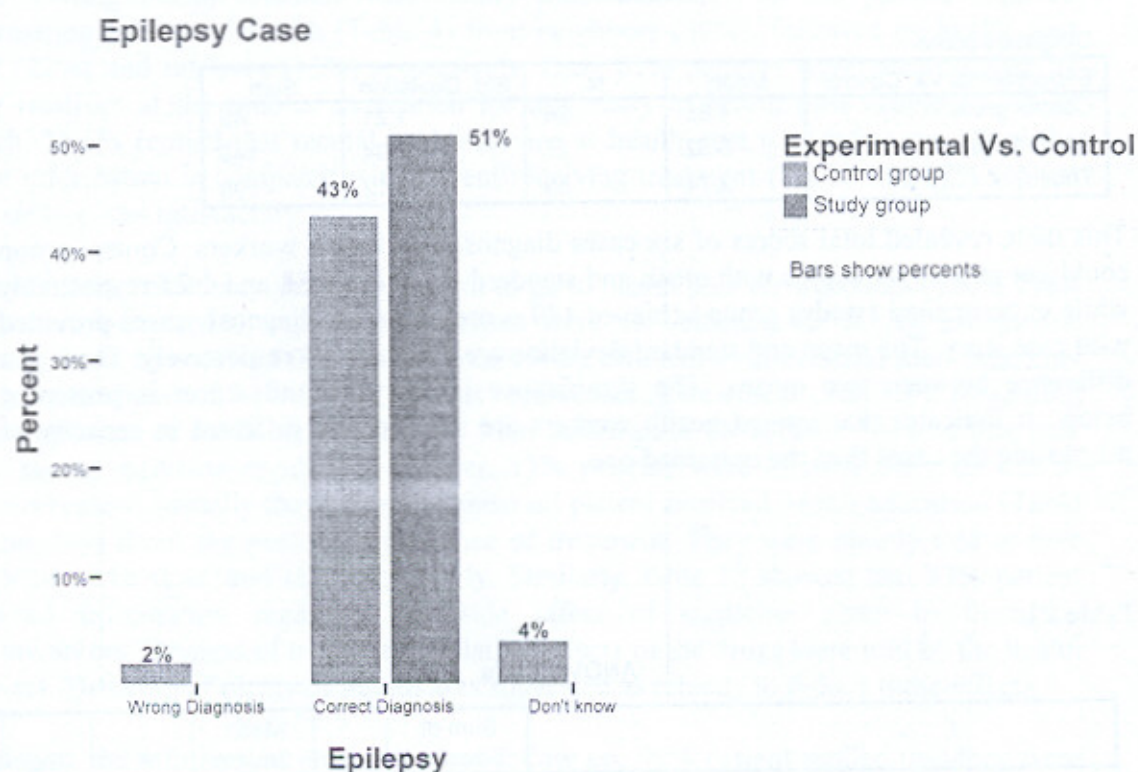
ANOVA Table

		Sum of Squares	df	Mean Square	F	Sig.
Diagnosis score * Experimental Vs. Control	Between Groups (Combined)	174.907	1	174.907	150.2	.000
	Within Groups	59.395	51	1.165		
	Total	234.302	52			



## 5.4 Individual case diagnosis profile in two groups

Figure 2

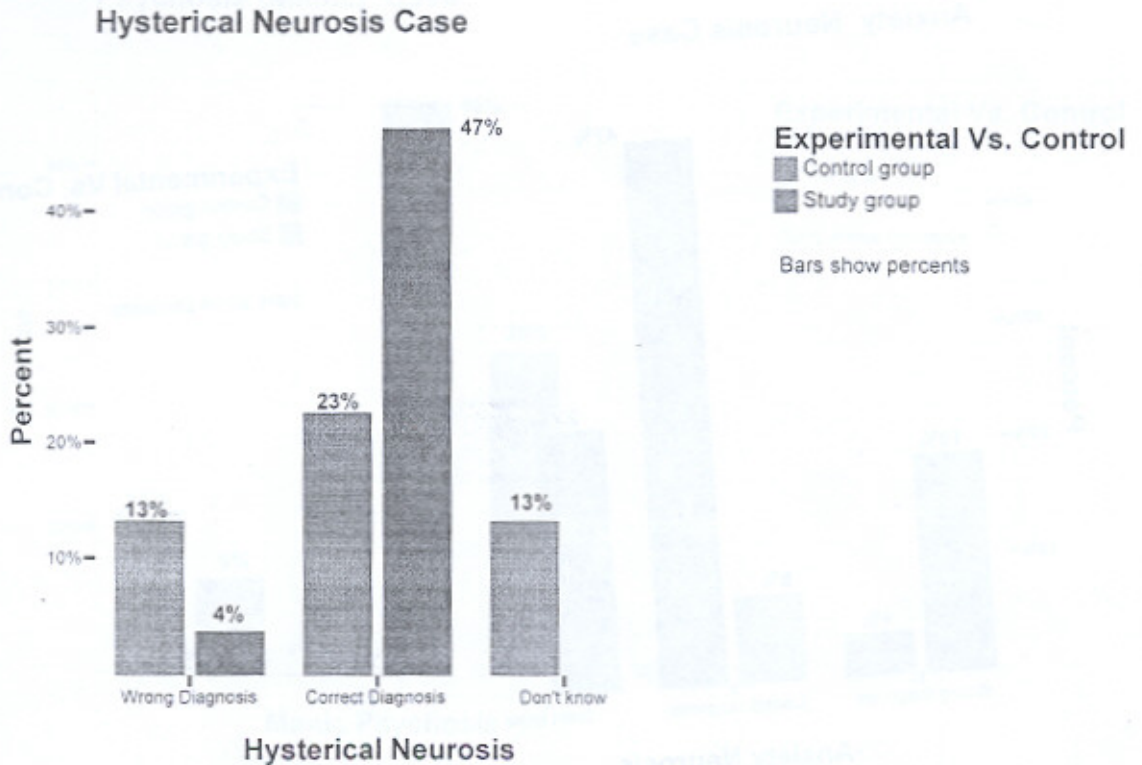


**Epilepsy \* Experimental Vs. Control**

			Experimental Vs. Control	
			Control group	Study group
Epilepsy	Wrong Diagnosis	N	1	
		%	1.9%	
	Correct Diagnosis	N	23	27
		%	43.4%	50.9%
	Don't know	N	2	
		%	3.8%	
Total	N	26	27	
	%	49.1%	50.9%	

In first case, experimental group could diagnose all cases (51 %) correctly while control group also could diagnose 43 %. There are no evidences of wrong diagnosis or not able to make diagnosis in the experimental group but it is seen in control group.

Figure 3



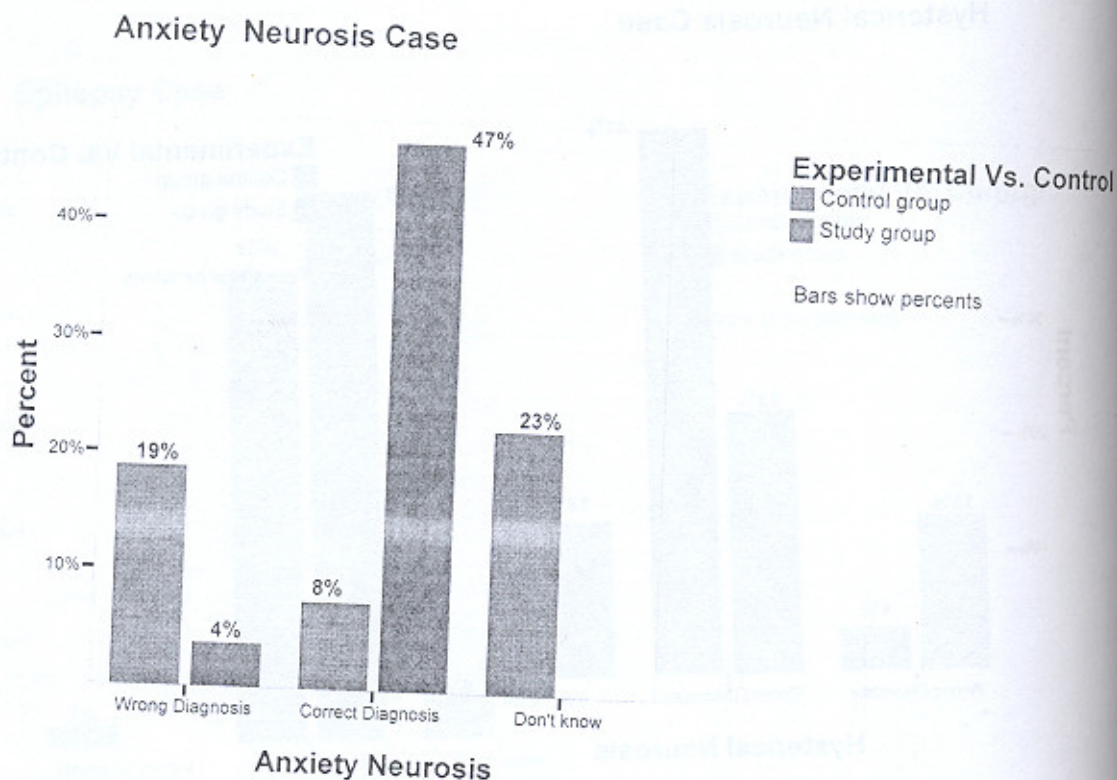
Hysterical Neurosis \* Experimental Vs. Control

			Experimental Vs. Control	
			Control group	Study group
Hysterical Neurosis	Wrong Diagnosis	N	7	2
		%	13.2%	3.8%
	Correct Diagnosis	N	12	25
		%	22.6%	47.2%
	Don't know	N	7	
		%	13.2%	
Total	N	26	27	
	%	49.1%	50.9%	

Above table shows the distribution of diagnosis pattern of case of hysterical neurosis. High percentage of diagnostic accuracy is seen in study group than the control group. The wrong diagnosis or not able to make diagnosis pattern also increased in control group than the experimental group as shown in figure.



Figure 4

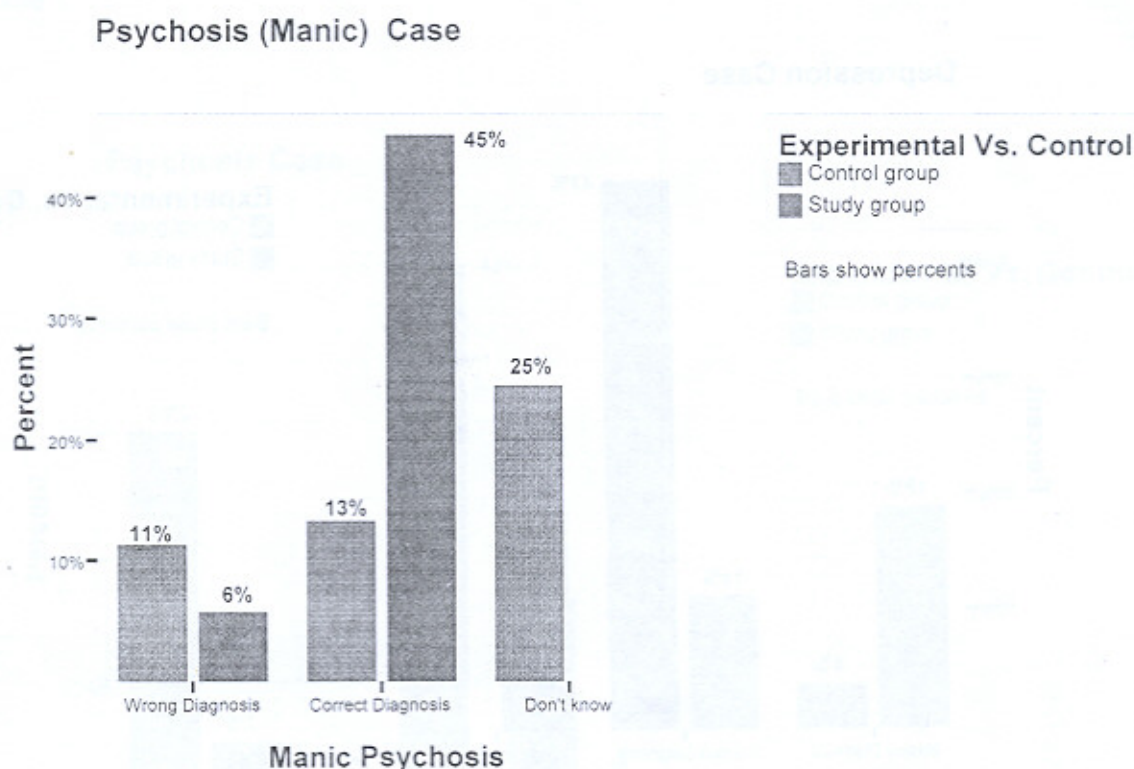


Anxiety Neurosis \* Experimental Vs. Control

			Experimental Vs. Control	
			Control group	Study group
Anxiety Neurosis	Wrong Diagnosis	N	10	2
		%	18.9%	3.8%
	Correct Diagnosis	N	4	25
		%	7.5%	47.2%
	Don't know	N	12	
		%	22.6%	
Total		N	26	27
		%	49.1%	50.9%

Table shows that the accuracy of diagnosis is decreased very much in control group than the experimental group. Other categories such as not able to make diagnosis and wrong diagnosis has high percentages of distribution in control group.

Figure 5



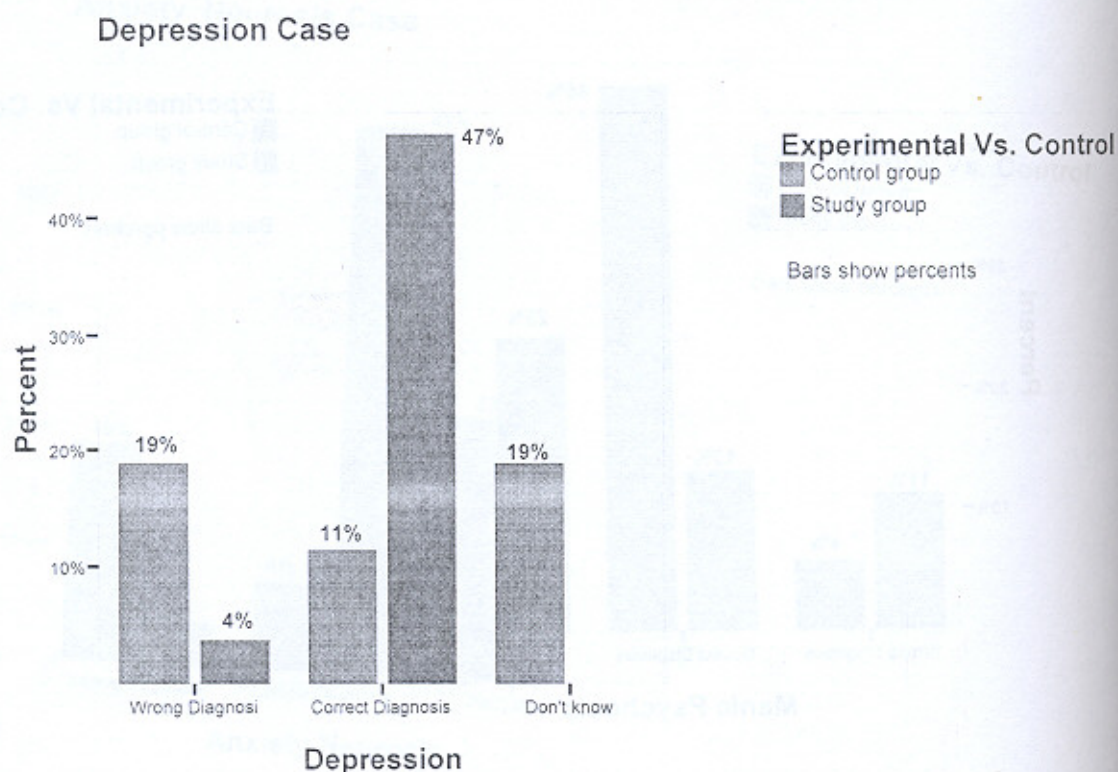
Manic Psychosis \* Experimental Vs. Control

			Experimental Vs. Control	
			Control group	Study group
Manic Psychosis	Wrong Diagnosis	N	6	3
		%	11.3%	5.7%
	Correct Diagnosis	N	7	24
		%	13.2%	45.3%
	Don't know	N	13	
		%	24.5%	
Total	N	26	27	
	%	49.1%	50.9%	

The diagnosis pattern of case of manic psychosis revealed almost same observation as like above cases where the highest accuracy in making diagnosis is seen in trained health workers group than untrained healthworkers. Only 13 percent health workers could diagnose this case accurately while 45 percents trained health workers out of 51% could diagnose the case.



Figure 6

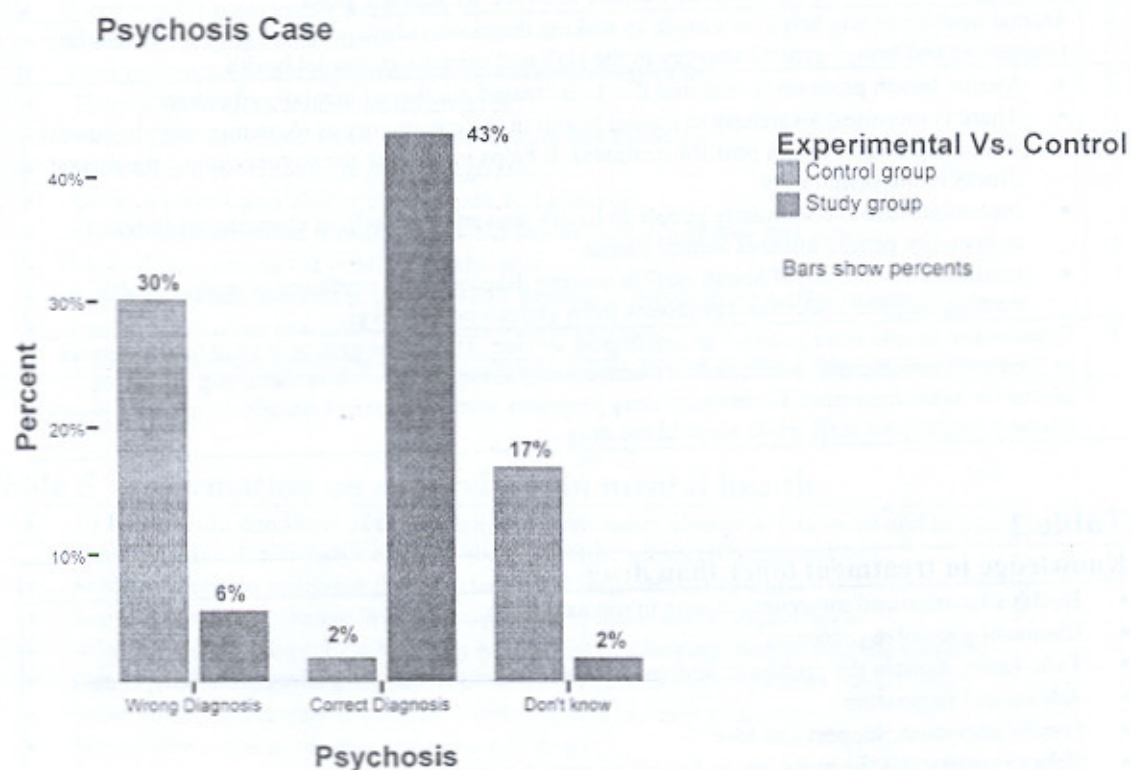


Depression \* Experimental Vs. Control

		Experimental Vs. Control		
		Control group	Study group	
Depression	Wrong Diagnosis	N	10	2
		%	18.9%	3.8%
	Correct Diagnosis	N	6	25
		%	11.3%	47.2%
	Don't know	N	10	
		%	18.9%	
Total	N	26	27	
	%	49.1%	50.9%	

Diagnosis pattern of Depression case showed 47 percents health workers from trained group could diagnose the case correctly while much less in untrained group (11 percents). High percentages of healthworkers in control group were either made wrong diagnosis or not able to make diagnosis.

Figure 7



Psychosis \* Experimental Vs. Control

			Experimental Vs. Control	
			Control group	Study group
Psychosis	Wrong Diagnosis	N	16	3
		%	30.2%	5.7%
	Correct Diagnosis	N	1	23
		%	1.9%	43.4%
	Don't know	N	9	1
		%	17.0%	1.9%
Total	N	26	27	
	%	49.1%	50.9%	

Diagnostic pattern of psychosis case describes that 43 percent trained health workers out of 51% were able to make correct diagnosis while only 2 percent from untrained group could make correct diagnosis. So it revealed significant differences in diagnosis skills in two groups.



## 5.5 Result of Qualitative information from healthworkers

### Information from trained health staff

Table 1

Changes occur due to mental health service at health post	
1	Mental health training helps very much in making diagnosis (identification), treatment including counseling and brings general changes in the skill and capacity in mental health.
2	<ul style="list-style-type: none"><li>• Mental health program is essential due to increased number of mentally ill patients.</li><li>• There is increased awareness in mental health in the community as more mentally ill patients were attending to health post for treatment. It helps in diluting the stigma against the mental illness in the community.</li><li>• Increased trust of community people to health post and also help in changing attitudes of community people towards mental illness.</li><li>• Increased confidence of health staff in making diagnosis and treatment as mental health training helps to understand problems from various perspectives.</li></ul>
3	Community people were positive to health post service. They were getting mental health service in their own community, which reduces unnecessary expenditure such as travelling to remote places for same treatment. Community drug programs some time affect negatively as some people blame it health post staff while we sold the drug.

Table 2

Knowledge in treatment other than drug
<ul style="list-style-type: none"><li>• Health education and awareness raising in mental health.</li><li>• Counseling to solve problems.</li><li>• Talk, listen, explain the problems, and encourage to make mentally ill patient more independent.</li><li>• Advice and suggestion</li><li>• Family education, support and love</li><li>• Help to understand the problems and guide to get solution.</li><li>• Support mentally</li><li>• Love, affection</li><li>• Helpful attitude towards mental patients</li><li>• Psychological support</li><li>• Ask patients to seek traditional healers treatment.</li><li>• Problem solving skills such as yoga, meditation.</li><li>• Psychotherapy –indigenous form such as Jyotishi, Ddhami, lama</li></ul>

Table 3

Perception of mental health service provided from health post
<ul style="list-style-type: none"><li>• People were aware that mental illness is not communicable disease, cured well if there is treatment on time.</li><li>• People felt that treatment is easy, curable and cheap.</li><li>• People were happy that treatment is available at local health post, need not to visit big hospital. Mentally ill patient could cure equally even from health post treatment though the duration can be varied.</li><li>• This service increased trust of community people towards health post.</li><li>• Easy drug availability to poor patient is necessary to make mental health service effective and accessible to poor people.</li></ul>

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**Table 4 Difficulties faced while providing mental health services**

- Lack of regular supply of mental health drugs at health post. They were even not supplied in local medical shop.
- There is shortage of trained manpower to provide this service from health post.
- People often blamed that health post staff were selling drugs instead of giving freely as government has provided it.
- Need regular supervision and follow up.
- Difficulty in time management
- Poor patient could not buy medicine, so have difficulty to treat.
- There is difficult to follow defaulter cases.
- Patient flow decreased when we asked them to buy medicine.
- Some time it is difficulty to make diagnosis.
- Drugs were not available at cheaper rate in the market.
- Mental health training is needed to all the health staff to continue this service.
- Lack of trust among the public to health post.
- Regular seminar, workshop, and refresher training is necessary in mental health.
- Patient visits often to traditional healers than health post
- Lack of awareness in mental health as there is stigma against mental illness in the society.

**Table 5 Information on supervision in mental health**

- To know detail condition of the patient, make necessary change in treatment and to make the service more effective. It also helps to know about the effectiveness of treatment.
- Supervision helps to refresh the knowledge and skills of trained staffs.
- Supervision brings change in performance and to make aware on problems.
- It helps to know the problem faced by health post and helping them to find the solution.
- Due to lack of supply of drug supervision is not necessary as no patients were visiting.
- Supervision is necessary to provide counseling and increase awareness.
- Supervision helps to observe any misuse of drugs.
- Supervision is necessary for the satisfaction of patient as experts were visiting to health post.
- Public believes more on supervision team.
- To review any difficult case in diagnosing, treatment, prognosis and provide necessary instruction.
- Supervision is necessary to know any shortcoming of the program and improve it accordingly.
- Frequent supervision increased trust of patients towards mental health service and also increased patient flow.
- It provides opportunity to be familiar with patient and increased confidence about diagnosis and treatment.
- Supervision helps in arranging training, discussing difficult cases with consultant, taking class in training etc. It helps to systematize the reporting system.
- It would be effective if we have one mental health supervisor at district level and conduct supervision regularly.
- Supervision should not just provide direction. It has to be effective.
- Supervision provide chance to learn more from the experience.
- Supervision has to be done while health workers were examining the cases and he/she must be competent and skillful and dedicated to work.
- The components of supervision such as motivation, training and suggestion are helpful to explore solution of the difficulties experienced while working and helps to evaluate the effectiveness of program and give necessary direction.
- Supervision facilitates in the rehabilitation of patient in his or her own community so that patient will become more productive and can lead effective life.

**Table 6 Information on integration of mental health service**

- Integration is necessary (all except one participants agreed). Integration could be done as like TB, Leprosy and Malaria but needs regular support from mental health specialist.
- Integration could be done through coordinating with HMG and by developing regular work plan.
- Mental health service to be integrated, provide mental health training to all the health post staff, make availability of free drug as far as possible, provide regular service for mental patient rather than fixing certain clinic day in health post.
- Mental health problem is also a public health problem, if we left it from mainstream, we could not fulfill the objectives of HMG to make available of basic health service at grass root. Basic training, refresher training and regular supervision is necessary.
- Mental health service at health post level increases the trust of community people towards health post service because it reduces economic burden of the patient.
- Mental health service at health post facilitates that patient could get service on time. But HMG has given less priority to this service.
- Health post can provide this service using the same facility and manpower so it is cost effective as well for government.
- There were many mentally ill patients in the community and it is a public health problem as well. So it has to be integrated with the existing service and government has to provide mental health drugs at health post.
- Needs cooperation from each other and right use of manpower.
- Mental health activities are also major activities for the community.
- All kinds of patient visit to health post.
- Integration can be done through coordination between public health department and training center or hospital.
- For the continuity of current mental health services in future integration is necessary.
- More number of mental patient attend health post or hospital as shown by the research that there were increased number of mental problems as a whole. Integration can be done giving mental health service also equal importance as like other health services by the government. But we need trained manpower, supply of drugs and system of recording and reporting in mental health.
- Mental health is also a part of health. Integration can be done through mobilization of health post staff.
- It can be done through adding the mental health component in primary health service system.



**Table 7 Information on recording and reporting system**

**Usefulness of current recording and reporting system in mental health**

- Current recording system is helpful (all except three agreed).
- It helps to know the total number of patient, provide treatment and make diagnosis.
- Recording helps in supervision and gather of mental patients.
- Recording system makes easy in work such as knowing types and number of patients, progress of patient and treatment.
- Current recording format has to be changed. Patient card is larger, print register book alphabetically from center and supply to health post and patient yellow card has to be covered with plastic.
- It also helps in reporting.
- Facilitates supervision whether patients were getting better or not.
- To get service easily and quickly.
- To know the type of illness from the card and number of such patient in the health post area..
- Recording can be done through the use of cards, supervision and training.
- It provides information on stock of drugs and type of mental illness. Current HMIS form column 32 is insufficient to provide all these information.
- Recording helps to know the nature, type of illness, defaulter case, recovered, treatments completed, follow up date, supervision and flow of patient. It is easier to call the patient and follow up.
- It helps to evaluate the progress of patient such as to know the effectiveness of treatment, duration of treatment provided, any modification to be done in the dose of drug etc.
- Improvement is needed such as there are unnecessary columns and headings in the forms. All the recording materials have to be reached health post on time.
- Recording system has to be integrated by district health office as like other health service. Mental health service has not yet integrated in to the general health system. So it did not help much.
- Reporting has been done including in to HMIS form to district health office from where it goes to health service department.
- Recording of mental health service has been reported to mental health project, Pokhara.
- Reporting to district health office and western region community mental health program.

## 5.6 Information from health staff control group

Table 8

### Providing mental health service from health post

Yes we are providing mental health services from health post (13 participants)	No, we are not providing mental health services from health post (12 participants)
<ul style="list-style-type: none"><li>• As like other OPD services</li><li>• Mentally ill patients were also coming to health post in addition of other patients. But we don't know how to treat.</li><li>• Simple supportive help can be provided</li><li>• We do treat mentally ill patients with Phenobarbitone or alprazolam.</li><li>• To provide cheap service for mentally ill patients.</li><li>• Many mentally ill patients could not visit to big hospital due to poverty.</li><li>• It is our responsibility to encourage such patients.</li><li>• Simple treatment and reassurance can treat many mental illnesses.</li><li>• Because of the need of patients, simple service is provided and referred if needed.</li></ul>	<ul style="list-style-type: none"><li>• We don't have training in mental health and refer to other center where service is available.</li><li>• Lack of training and proper supply of medicine.</li></ul>

Table 9

### Difficulties faced while providing mental health service from health posts.

Challenges and difficulties
<ul style="list-style-type: none"><li>• Patient may not visit to health post.</li><li>• Problems in compliance of medicine and controlling of their destructive behavior.</li><li>• Health staff are not trained in mental health so have difficulty in diagnosis, counseling and treatment.</li><li>• Management of drug supply as mental health drug is not available at health post.</li><li>• Difficulty to treat psychosis and status epilepsy because of lack of resources.</li><li>• Regular supervision from mental health experts.</li><li>• Health staff were not experienced in treating the mental patient.</li><li>• Problems of availability of bed if need to be hospitalized in PHC.</li><li>• It is not integrated in to basic health care system in the government.</li><li>• Public trust towards health post may decrease due to inability treat effectively.</li></ul>

Table 10

### How mental health services can be provided from health post

<ul style="list-style-type: none"><li>• Providing basic mental health training to health workers of health post.</li><li>• Make arrangement of basic mental health drugs at health post.</li><li>• Provision of refresher training and supervision from mental health specialist.</li><li>• Regular follow up is essential to mental patient to see the effect of drug.</li><li>• Family role has to be explained to the family off such patient.</li><li>• Awareness raising activities in mental health at local level is necessary so that such patient will be referred to health post.</li><li>• Mental health clinic can be run either monthly or weekly from health post if staff receives training.</li></ul>
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**Table 11****Information on integration of mental health service at health post**

- Mental health is also health-related program. Trained manpower and availability of drug is necessary to start mental health service. It would be effective if we can establish a separate mental health section in the district health office from where this program can be run to health post and sub-health post. Awareness raising activities in mental health is equally necessary.
- To provide easy and cheap service, it can be integrated.
- Community would be more aware in mental health as social and environmental factors were considered main cause for mental illness.
- Integration helps to achieve the goal of health service. Integration can be done by running mental health clinic once a week and provide awareness raising activity at local level.
- Integration is necessary to make mental health service effective.
- Many mental patients were visiting to health post. It is necessary to include within health post service so that many poor patients could benefit as they are having financial problems.
- Mental health problems are also public health issues. Integration can be done through providing training to health workers and start mental health activities in an integrated manner with other activities.
- Patient would be benefited from all aspect if it can be integrated.
- Integration helps in recording and reporting system and includes in to HMIS form column 32.
- To make available of mental health service throughout the country like other health service.
- Provide training and use strategy of active case findings.
- There is increased stress in daily life that can cause many people to suffer from mental illness. So mental health service is essential and has to continue regularly such as one or two days in a week.
- From the same physical facility and staff of health post, this service can be provided as like other health service.
- Recording and reporting will be on time and properly.

**Table 12****Information on the need of supervision in mental health**

- Follow up is essential to know how much work has been done and to know the outcome as well.
- It helps to know overall progress of patient and number of patient treated from health post.
- Mental patient takes longer time to recover.
- Supervision enhances the quality of mental health services.
- To analyze the activities such as knowing prevalence of the mental health problems.
- We can do follow up of the patient even for defaulter case using our own staff or local resources such as female health volunteers. It would be better to have supervision from higher authority in every 6 months on how the service is running.
- For the achievement of program activities and improvement.
- To maintain records such as number of visit, improved case, cases under treatment, number of new patient added etc.
- To evaluate the effectiveness of working skill of staff and provide feedback.
- To identify any weakness or problem in the service and correct them on time.
- To ensure the compliance of treatment due to poor level of awareness.
- To provide quality and reliable service in mental health.
- Supervision helps in solving the clinical problems such as diagnostic confusion, to bring uniformity in treatment, to know and update the relevant technique and use them in practice.

**Table 13**

**Information regarding the need of recording system**

- All the participants agreed the need of recording and reporting system
- Recording can be done making separate register.
- Recording is necessary to know to know information about patient on socio demography, prognosis and need of drug.
- Recording can be done making separate filing system and register for mental health service. Following heading can be created in the register-name, sex, age, address, marital status, occupation, type of mental illness, new or old case, treatment, any advice given to family and follow up notes. Separate columns can be made on each heading to record information.
- Recording helps to know about the number of health workers involved to provide service.
- To evaluate the effectiveness of activity and knowing the situation of mental health problems in the country and develop strategy on treatment.
- Recording is necessary to provide information to the concerning authority if asked.
- Recording helps to know how many mentally ill patients were receiving treatment in mental health.
- Recording is necessary to know the number of patients visited, treatment provided, effectiveness of service, and make future plan. Recording can be done in daily treatment register, keeping monthly record and a separate form can be developed.
- We can maintain record adding a separate section in monthly progress report for mental health.
- Recording is necessary to get information on the nature of problems and their remedies taken.
- Recording can be done following HMIS form.
- All mental illness could not be specified only in mental disorder or epilepsy column. A separate HMIS form for mental health has to be developed.
- Recording is necessary for reporting and maintaining data.
- Recording can be done making a separate code in OPD in the morbidity form.
- Recording is necessary for reporting and monitoring.
- It would be better if Ministry of Health can develop separate space for mental health in HMIS, so that it can be implemented in all part of the country uniformly. If it is not possible, one separate page can be developed from district health office, which consists information such as name, address etc.



## 5.7 Information from Community focus group discussion

**Table 1**  
**Information on definition of Health**

Community where mental health service is available	Community where mental health service is not available
<ul style="list-style-type: none"> <li>• Free from disease, dirt and disability</li> <li>• Being fit and sound from all aspect</li> <li>• Physically and mentally healthy</li> <li>• Maintained personal and environmental hygiene</li> <li>• Is capable to work.</li> <li>• Capable to fulfill all the needs.</li> </ul>	<ul style="list-style-type: none"> <li>• Free from illness / disease</li> <li>• Being healthy and physically fitness</li> <li>• Being right from all aspect</li> <li>• Maintain hygiene and environment</li> <li>• Have good diet</li> <li>• Being more mental awareness.</li> <li>• Capable to work physically and mentally.</li> </ul>

**Table 2**  
**Information on definition of Mental Health**

Community where mental health service is available	Community where mental health service is not available
<ul style="list-style-type: none"> <li>• Being free from mental tension, anxiety and worries</li> <li>• Able to think properly</li> <li>• Person who can bear mental tension.</li> <li>• Being healthy from all aspects.</li> <li>• Have good relationship in family and others.</li> <li>• Adequate functioning of sensation or no disorder in brain.</li> <li>• Able to tackle if there is any problems.</li> <li>• Don't know (3 participants)</li> </ul>	<ul style="list-style-type: none"> <li>• Keep mind peace</li> <li>• Ability to remember well</li> <li>• Free from worry, tension, sorrow and unnecessary thinking</li> <li>• Have proper mental fitness.</li> <li>• Proper working of brain</li> <li>• Ability to control activities by self</li> <li>• Free from disease.</li> <li>• Have good environment and free from alcohol.</li> <li>• Can think and response appropriately to the situation and analyze what is right or wrong.</li> <li>• Don't know (2)</li> </ul>

**Table 3**  
**Information on causes of mental illness**

Community where mental health service is available	Community where mental health service is not available
<ul style="list-style-type: none"> <li>• Frustration due to unfulfilled desires or wishes</li> <li>• Poor frustration toleration ability</li> <li>• Increased demand and limitation</li> <li>• Increased tension, anxieties, worries and stress.</li> <li>• Relationship problems</li> <li>• Heredity</li> <li>• Negative major life events such as failure in study</li> <li>• Disease in brain</li> <li>• Lack of love and affection</li> <li>• Chronic pophysical illness</li> <li>• Too much study</li> <li>• Family conflicts</li> <li>• Thinking excessively or increase heat in the brain</li> <li>• Lack of food and awareness</li> <li>• Lack of adequate pressure inside the brain</li> <li>• Due to influence of witchcraft</li> </ul>	<ul style="list-style-type: none"> <li>• Poverty</li> <li>• Accident-brain injury</li> <li>• Stressful incidents -loss of property, death</li> <li>• Excessive anxieties or worries</li> <li>• Lack of family and social support</li> <li>• Decreased frustration toleration power.</li> <li>• Lack of opportunity</li> <li>• Fainting attack</li> <li>• Heredity</li> <li>• Hot blood increased aggressive behavior</li> <li>• Drinking of excessive alcohol / drug abuse</li> <li>• Shading tears excessively</li> </ul>



Table 4

## Information on treatment availability

Community where mental health service is available	Community where mental health service is not available
<ul style="list-style-type: none"> <li>• Basic treatment is available at health post.</li> <li>• Have to take to Palpa, Pokhara, Narayanghat, Kathmandu or even India if not getting better from health post treatment.</li> <li>• Take such patient to traditional healers.</li> <li>• Treatment is not available at Damauli Hospital</li> <li>• Don't know (2 participants)</li> <li>• Treatment is available at Damauli Hospital</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment is not available at health post and has to take to Tansen hospital, Butawal, Kathmandu or India.</li> <li>• Treatment is available at Dhulikhel</li> <li>• Has to take to traditional healers for treatment</li> <li>• Not available in Nepal (Tanahu)</li> <li>• Don't know (4 participants)</li> </ul>

Table 5

## Information on signs and symptoms of mental illness

Community where mental health service is available	Community where mental health service is not available
<ul style="list-style-type: none"> <li>• Abnormal behavior such as being naked, withdrawal behavior, wandering aimlessly, neglect in personal hygiene, suicidal attempt, drinking alcohol excessively, have put in restrain often due to difficult to control, talking excessively and irrelevantly.</li> <li>• They were called '<i>boulaha</i>'</li> <li>• Fainting attack with frothing in mouth, sudden felt down,</li> <li>• Have no insight and orientation.</li> <li>• They did whatever they like without considering social realities.</li> <li>• Smokes cannabis or cigarettes</li> <li>• Shaking of body when eating specific food</li> <li>• Talking to the self</li> <li>• Mental retardation as they are slow in understanding things.</li> </ul>	<ul style="list-style-type: none"> <li>• Fainting attack</li> <li>• Self talking, talking excessively or irrelevantly, not talking with others, forgetfulness, suicide</li> <li>• Wander aimlessly, playing with excreta called '<i>boulaha</i>'</li> <li>• Scolding or abusive to others</li> <li>• Social withdrawal</li> <li>• Headache due to too much thinking or worries.</li> <li>• Showing odd behavior such as getting easily angry, not talking, eating carelessly, talking too much, poor personal hygiene.</li> <li>• Children could not study</li> <li>• Have no insight and judgment power.</li> <li>• No smile in face while talking</li> <li>• Don't know (participants)</li> <li>• Mental retardation – slow to think and act.</li> </ul>

Table 6

## Information on improvement to be done in mental health service at health post

Community where mental health service is available	Community where mental health service is not available
<ul style="list-style-type: none"> <li>• Lack of trained manpower in health post.</li> <li>• A separate section in health post is needed to treat mental patients.</li> <li>• Awareness program in school area to make aware teachers and students in mental health.</li> <li>• Continue available of mental health service in future as well.</li> <li>• Availability of mental health drugs freely at health post.</li> <li>• Visit by mental health expert at least once a month.</li> </ul>	<ul style="list-style-type: none"> <li>• Available of mental health service from health post as well.</li> <li>• Training in mental health for health post staff so that service is available at community at low cost and quickly.</li> <li>• Mental health specialist visit at health post</li> <li>• Awareness activities at health post</li> <li>• Government has to provide mental health service freely.</li> <li>• Survey of blood to find out the risky group of people.</li> </ul>



**Table 7****Information on behavior shown towards mental patients**

Community where mental health service is available	Community where mental health service is not available
<ul style="list-style-type: none"> <li>• Our behavior towards mental illness is not appropriate and has to help them in treatment and provide love.</li> <li>• Should be supportive</li> <li>• Mentally ill were ignored, not accepted and taken care by family and society.</li> <li>• try to understand the worries and problems of such patient and help accordingly.</li> <li>• Due to stigma family people were not behaving well with such patients so, we have to help to minimize it and increase support.</li> <li>• Need patience while dealing with such patients.</li> <li>• Often such patients were beaten or restrained at home which is not human treatment.</li> <li>• Family has to provide food, medicine and care.</li> <li>• We were taking them to traditional healers for treatment earlier but now we were taking them to health post for treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• Family have to provide medicine regularly</li> <li>• Provide emotional support and safety to such patient.</li> <li>• Provide proper food</li> <li>• Do not show provoking behavior</li> <li>• We afraid as we don't know how to behave with mental patient (mad case). So we often avoid them.</li> </ul>

**Table 8****Information on the role of family in treatment**

Community where mental health service is available	Community where mental health service is not available
<ul style="list-style-type: none"> <li>• Family needs to have understanding of mental patient's problems.</li> <li>• Take responsibilities in treating, feeding, and helping them to maintain personal hygiene.</li> <li>• Good family relationship helps in quick recovery. They should not be ignored, discriminate or punish.</li> <li>• Needs treatment of any physical problems on time.</li> <li>• Help in treatment such as provide medicine on time, regular follow up at health post.</li> <li>• Family has to be supportive and be resourceful to minimize the symptoms or distress.</li> <li>• Ask with doctor or health post staff how family has to behave with such patient.</li> <li>• We have to listen carefully worries and anxieties of such patient.</li> </ul>	<ul style="list-style-type: none"> <li>• Family has to behave properly in food, personal hygiene, and emotional support.</li> <li>• Help in treatment, take to Health post for regular treatment, provide medicine on time.</li> <li>• Take to traditional healers for treatment.</li> <li>• Family has to be supportive, provide reassurance, talk well and do not get angry.</li> <li>• Do not leave patient alone</li> </ul>

Table 9

## Information from the Observation of Mental health Clinic

Activities	Name of HP / PHC	Run by	Remarks
Mental health Clinic	Dumkoui PHC, Nawalparasi	WRCMHP team	<ul style="list-style-type: none"> <li>WRCMHP team was mainly running mental health clinic.</li> <li>No participation from trained health workers to run clinic.</li> </ul>
	Lumbini PHC, Rupendehi	Jointly with PHC staff	Trained staff from PHC also involved with WRCMHP to run the clinic
	Walling PHC, Syangja	Jointly	Trained staff from PHC lead the clinic with WRCMHP team
	Deurali HP, Kaski	WRCMHP team	WRCMHP team runs the clinic. Trained staff absent
	Damouli Hospital, Tanahun	Jointly	Both trained staff from hospital and WRCMHP team were involved to run mental health clinic.

## Remarks detail information

- Mental health clinics run once a month as a satellite clinic.
- Mental patients if visit other than mental health clinic day, were not seen and told to come only the clinic day though the same health person is looking them even in the clinic day. Rarely they were seen in general clinic if trained health worker is wise and enough responsible towards patient. It definitely increased workload to them and also were not appreciated or valued for their hard working from the management.
- Incident of cancellation of clinic were also noted when staff from WRCMHP could not visit. So, the satellite clinics were heavily reliant on WRCMHP, which can threaten the sustainability of mental health service if WRCMHP phased out.



## **6.0 Discussion of the findings**

### **6.1 Sociodemographic variables of health workers**

Two groups of healthworkers were selected for the study. Twenty seven health workers that were trained in mental health made up the experimental group. Similarly, twenty six health workers were selected for the control group from the health facilities where mental health service were not available. The control group had no training in mental health. Table 1 depicts the detailed distribution of the health workers sample. Equal proportions of health workers were assigned into two groups i.e. experimental and control. 58.5 percent of health workers have higher education (table 2), which comprised 30.2% of the control group and 28.3% experimental group. Second higher education (table 3) 39.6% had SLC (School Leaving Certificate). Further analysis about higher education (table 3) showed that the majority (56.7%) had a intermediate educational degree, followed by 33.5% bachelor and 10% master degree in educational qualification.

Regarding professional categories (table 4) 58.5% were auxiliary health workers, while 39.6% were health assistant in both groups. Only one participant in control group was a public health supervisor. All the health workers in the experimental were of Hindu religion (table 5). This result was expected as majority of the population of the country follow the Hindu religion. Caste distribution (table 6) of the health workers showed that Brahmin was the most common caste (58.5%) the distribution followed by Chhetri and Newar as second and third greatest distribution. It is difficult to remark on this finding because of small sample of health workers were taken in this study.

Experimental health workers received 10 days mental health block training (table 7) from Western Region Community Mental Health Program to incorporate mental health services in to existing health care system. It is further displayed in figure 1. More than 54% health facilities selected for the study (table 8) were located in villages. It is commonly known fact that such facilities were established considering population distribution ratio and political and geographical region of the country (CBS, 2001). However, the experimental group population belonged to health facilities from municipalities (37%). WRCMHP implemented community mental health services in health facilities located in municipality area because of high patient flow rate. They were usually located close to the center of the district, which often tends to be municipality because of development.

The average age of health workers (table 9) in the control group was 33 years with the standard deviation of 8.5 and is followed by 39 years with standard deviation of 8.57 for the experimental group. The difference of mean age in the two categories is significant ( $p > .05$ , table 10). Similarly, the mean of work experience in two groups are 104.29 in control and 199.56 in experimental respectively. The difference of mean between two groups is strongly significant ( $P = .001$ ). Therefore, health workers in the experimental group were had more experience in their profession than control group. The pre-post test questionnaire scores revealed means of 24.27 and 33.04 in control and experimental



group respectively. The subsequent ANOVA table depicts that the difference is strongly significant ( $P = .000$ ). Similarly the means of total scores of case description are 24.27 and 33.04 in control and experimental group. Again the differences of mean between two groups showed high significant ( $P = .000$ ) in the same statistical analysis. This finding indicates a very encouraging result of mental health training, as trained health workers were still equally capable to retain significant amounts of mental health knowledge and skills. This positive result also supports the usefulness and effectiveness of mental health training curriculum designed as block training, supervision and refresher training in mental health for health staff in primary health care workers. Nakarmi (2004), in her recent study also found a similar result. Health workers (HA, CMA and ANMs) were equally capable to retain mental health knowledge and skills in the CDHP health post. Braganza et al. (1999) also valued the mental health training course for health workers. Participants of their evaluation report of WRCMHP expressed positive feedback about the contents of the training. The consistency in skill is due to the enforcement of regular supervision in the community mental health program.

## 6.2 Discussion of Findings of Patient Sample Descriptive Result

Patient sample information revealed the average duration of mental illness before visit to health post was 30 months (Table 12) and the average duration of receiving mental health treatment from health post is 24 months. Mental patient had to travel an average 64 minutes to reach the to health facilities from their home. The average waiting time for consultation with health workers, in health facilities, on the first visit was nearly 2 hours. Mental patients who were selected for the study have an average age of 30 years. There was wide range of variation for the distribution of individual age. So the mean value of these descriptive data cannot be considered as a real representative value of the sample population under this study. Though the selection procedure of sample is fairly strong (random selection) there were only a small number of patients selected for the study, which may not be representative of the entire cohort.

Higher percentages (61%) patients were female. This finding is similar with the earlier evaluation study in Lalitpur district (Wright, 1991) where more number of female were attended health post to seek service than male. Educational status of mental patient varied from illiterate to 7<sup>th</sup> grades. Over representation of female patient might be due to chance factor during selection process or more number of female patients registered in health facilities as well. Less number of male patients in the sample does not mean that mental illness is less prevalent to this gender. Males were often visiting city or different area for work. They might seek treatment where they worked if they had any mental health problems. Females usually were not having other options except seeking health service from health post near by their community. Annual report of western region also showed similar pattern as more female patients were getting mental health treatment from health post (Annual report of WRCMHP 2000-2001, 2001-2002).

Nearly two third majorities (65%) patient were married while looking marital status of patient (Table 15). Occupational distribution also affected by the gender representation in



the sample. As explained above, more females were in the study. Hence, housewife is the main occupation for female and is followed by student and farmer. Student as a second major occupation found in this study is due to having children cases of epilepsy of school age. Community mental health service earlier research also showed that epilepsy is the highest number of patient attended in health post where mental health service is available. Psychiatrist in addition of neurologist in this part of world looks after this disease. Other explanation to have mental problems in early age or student age might be because of the factors such as academic, socio-political or age related changes. Mahat (1999) in his study also claimed similar reasons for having mental health problems between child and young adolescent.

### **6.3 Discussion of Qualitative Information from Patient**

The comparison of diagnosis of mental patient made by trained health workers and mental health specialist (psychiatrist) showed 70% complete agreements followed by 26% partial agreement. Psychiatrists were evaluated independently same patients seen by healthworkers in health post. It showed that the trained health workers were also efficient to retain and practice of mental health skills in health post level. This finding could be the result of supervision from WRCMHP and keen interest of healthworkers to learn and practice the skills better. In the partial agreement category, both healthworkers and psychiatrist retained symptomatic diagnosis. The symptomatic diagnosis is made on the basis of presenting complain by healthworkers such as fainting attack in epilepsy. However, psychiatrists also provided possible differential diagnosis.

Treatment agreement comparison (table 2a, b) revealed that 43.5% patient treated by healthworker is fully agreed with psychiatrist treatment evaluation. The same amount of patient treatment is agreed partially between health workers and psychiatrists. Partial agreement category comprised either drug choice was agreed but the dose was not sufficient or some modification or addition of drug were suggested by psychiatrist. The detail pattern of information is provided in result table 2a. A similar finding was seen in earlier study (Wright, 1991) where treatment of epilepsy and psychosis involved low dose prescription of psychotropic drug. This is an important finding that healthworkers were also efficient both in identifying and treating mental patient in HP/ PHC as well if they were trained in mental health and provided supervision. So inclusion of mental health service into existing health care system is possible with respect to the efficiency of health workers if provision of mental health training, availability of psychotropic drugs at HP / PHC, and supervision from mental health specialist is ensured. This finding is equally supported the earlier findings from Isaac et al (1996).

Depression and epilepsy were over all the commonest diagnosis given to mental health patients attending the health post accounting for (78.3%) of all mental health diagnosis. The diagnosis pattern varies considerably from health post to health post. As we know that approximately 25% of patients presenting to PHC has identifiable psychological disorder and that majority of these will be suffering from depression and epilepsy.



Anxiety is under represented, may be due to small sample. Political conflicts in the country can be responsible for increasing incidence of depression.

The impact of awareness raising activities showed that mental patients (table 3 and 4) received information about the availability of mental health service at HP /PHC from neighbors, health staff visit to village for their work, and relatives respectively. So it showed that the mental health information has reached up to the grass root level that increased the flow of mental patient in HP / PHC. Family members were the main accompaniment with mental patient when they attended to HP / PHC for treatment. It is obvious fact that family member has first responsibility to look, in this culture. According to Jackson et al (1993) the greatest increase in referral rate was of patients with relatively mild psychiatric disorders. Result of the current study also supported it, as there were more mental patient of mild to moderate severity, attended more for the community services in Western Region. Chronic cases, in fact, were taken to mental hospital for treatment.

Similarly, result also presented the descriptive statistics regarding duration of illness before treating from healthpost mental health service, duration of treatment from healthpost and waiting time to get consultation from healthworkers in HP at their first visit. Patients were suffering in an average of 30 months of illness from mental illness and were on treatment in an average of 24 months from health posts. There is great dispersion in the range of duration of illness as shown in the result. Patients were traveling in an average of one-hour duration from home to health post to get mental health service and were waiting for an average of 1.55 hour to get consultation from health workers in their first visit in mental health clinic. Mental patients were consulted with the range of 30-45 minutes in their first visit, which is decreased very much in follow up from 5-10 minutes. The longer consultation time in mental health is due to the nature of consultation where trained healthworkers has to gather information sufficient amount to reach in the diagnosis. For general health problems the average time of consultation is only 2.7 minutes (Kafle, et al, 1996) which is different in mental health.

The effectiveness of community mental health service also assessed from the perspective of patient relatives. Findings (table 5) showed positive attitudes to the service as they were getting mental health services in their own community easily in cheaper price. They don't need to visit for consultation in big city even for minor problems. On the other hand health workers were residing in health post or in the village so they can meet and discuss any difficulty easily with health workers. The finding is similar with the study of Jackson et al. (1993) and earlier evaluation report of the WRCMHP (Isaac et al, 1996). It is reporting the effect of extending outpatient services into community or primary -care settings have shown increased inception rates and prevalence rates of treated disorder. Findings of the current study indicated increased referral rate of mental patient into health post service due to awareness program in community conducted by WRCMHP.

Patient information further supported it, as 96% of them expressed that (table 8) healthworkers were able to understand their problems. In the treatment, psychotropic drugs were prescribed for almost all patients, which was taken regularly by more than



88% patient. The information about the drug was provided to all patient as shown by the result. The content of such education showed that patient were told mainly about the regular use of drugs, possible duration of intake of drug, possible side effects and ways to minimize them. Again this finding is very much similar with the result of Wright (1991) study of Lalitpur District, CDHP community mental health program evaluation report where she wrote that community people would use Community Mental Health Service if it is made available at a community level.

Prognosis analysis revealed that more than 61% patients reported that they were feeling better almost 60-100 percent (Table 15). The prognosis was evaluated on the area of presenting complains, work efficiency, family life and social life. The report from patient relatives showed even more improvement of their patient condition from the treatment provided from health facilities. The impact of treatment seems to be effective from service consumer perspectives.

Health workers attempt of providing information regarding patient illness and role of family on it seems to be improved as result (table 18a) showed that only 35% mental patient reported that they got this information. It could be due to various reasons that why health workers were not able to deliver the information. Increased patient flow, few healthworkers trained in mental health, increased responsibility in health post as same person has to be responsible to do many other jobs despite of patient service such as administrative or dispensary etc, could be some of the reasons. Almost all the patents and their relatives demanded the regular availability of mental health service and supply of psychotropic drugs in health post. It was also similar in the finding of Nakarmi (2004) and Wright (1991).

#### **6.4 Discussion of information on paper case profile between experimental and control group**

Individual analysis performed for six different psychiatric cases provided in paper with brief clinical description to health workers to both groups of healthworkers. There is significance difference in the total scores obtained from two group from the diagnosis as control health workers (n = 26) scored only 49 as total score with the mean of 1.88 and standard deviation 1.21 while experimental group (n = 27) scored 149 total score with the mean 5.52 and standard deviation 0.94. ANOVA result proved the difference is highly significant ( $F = 150.2, P = .000$ ). So it showed the effectiveness and strength of trained healthworker in identifying mental patients. The finding patterns of six different mental cases were presented in figure 2-7 in the result. However, the finding need to be supported by the future study even in the same area once the community mental health program phased out and handed over to the government.

Case one was identified by more healthworkers of control group as well. It might be because of the case it self as epilepsy case was presented. Healthworkers have studied about epilepsy in their curriculum when they were trained. However, other mental illness were not included in their curriculum, so false diagnosis or don't know category has



fallen more responses in other cases in the control group which was not seen in trained healthworkers. The clinical picture provided for other five cases were not unfamiliar for control group healthworkers. They include anxiety neurosis, depression, conversion disorder, psychosis manic and psychosis. The scores on these five cases grouped to either wrong diagnosis or not able to identify in control group while scores were grouped mostly in correct diagnosis in trained healthworkers.

## **6.5 Discussion of qualitative information from healthworkers**

Trained health workers were asked question about the changes occur due to mental health service at health post. The reply showed that mental health service at health post increased capacities of healthworker, as they were efficient in identifying and treating mental cases. The increased flow of mental patient at health post indicates that the service is getting popular and increased trust towards it in the community people. It was also supported from community focus group interview information. The awareness in mental health helps to change attitude of community people as they were positive to such services and encouraged affected people to go to health post. Furthermore awareness helps in diluting the prevailing stigma against mental illness in society. Nakarmi (2004) study also supported this result as capacity of health staff, trust of community to health post service and community awareness were equally reported in her study as well.

The recovery cases of mental patient from health post treatment also helped to increase trust in mental health service. It also facilitated to change the attitude that mental illness is treatable from healthpost. Relatives of mental patient also felt less discrimination in society once they started treatment and decreased the symptoms of illness. Economically it was great relief for the family of mental patient, as they need not to travel to big hospital. However, health workers have raised some demand to mental health service as patient has to take medicine for long period of time which is beyond their capacity due to poverty as such patient already lost their productivity and were unable to earn money for it. Free and regular supply of mental health drugs as like other essential drug would make mental health service beneficial really for poor patient. It is a cornerstone for the integration of mental health services in to existing health care systems.

Control group healthworkers also replied that they were providing mental health service which is mainly information giving for treatment (referral). They agreed that mental health service is needed in health post because mental patient often visits there for treatment. However, healthworkers were not equipped with the skills in mental health, so they are referring to cities where such service is available. Poor patient could not travel far place to get treatment. They mostly wander around the village. So, mental health service at health post is essential for such patient. Healthworkers from this group also demanded mental health training, ensuring the provision of psychotropic drugs, regular supervision from specialist and awareness raising activities in mental health, if we run mental health service from health post.



All the healthworkers in experimental group were mainly equipped with drug treatment knowledge through mental health training. Mostly they were providing education to patient on how to use drugs regularly and minimizing its side effects. Only few healthworkers were aware about importance of psychological treatment for mental patient. Otherwise supportive component has been used frequently. This is obvious that they were not trained in psychological way of treating mental patient. Even some healthworker has perceived traditional healing system as psychotherapy, which is partly true but not all because the reassurance and emotional support are the most frequently used component in traditional healing system. It was found strong psychological device to enhance confidence of mental patient for some period of time but may not persist longer period if problem is chronic (Mahat, P. 1997)

Healthworkers also faced difficulties while providing mental health service in healthpost. The most difficulty arised due to lack of regular supply of mental health drug, as they were even not available in local market as like other health drugs. The system of selling drug from health post also is not very much helpful for the poor mental patient, as they were not able to buy it. So they had to rely either on traditional healers available at village.

Lack of trained manpower in health post was another difficulty replied by healthworkers. WRCMHP has full coverage of it's program only in two districts of western region i.e. Kaski and Syangja. In other district it has served from only one point of district where not yet all health workers were trained. Those who were trained, due to any reason, if could not run the clinic, might affect the service. The other major difficulty of the existing health care system is frequent transfer of healthworkers. It almost strikes to mental health service if the trained person is transferred to other health post. The lack of adequate awareness in mental health has still created challenge on the sustainability of mental health service. The untrained healthworkers (control group) were also raised similar issue such as lack of supply of psychotropic medicine, lack of training and supervision in mental health, which affects in the success of program.

## **6.5 Information on Supervision in mental health**

According to trained healthworkers, supervision is necessary to make mental health service regular and effective. It helps in strengthening the skills of healthworkers. Management supervision helps to make health post service including mental health more systematic and regular. Any difficulties such as recording, reporting, drug supply or any other difficulties can be discussed and facilitate to search the options. Clinical supervision strengthens the skills of healthworkers in mental health so that more quality service can be provided.

Healthworkers from control group also emphasized the need of supervision both management and clinical in mental health for systematic service of good quality. Regarding the sustainability of supervision, few trained healthworker replied that district level supervisor need to be developed who can do the work effective in the district.



However, clinical supervision seems to be enforced by the psychiatrist to strengthen the clinical skills of health workers in mental health.

## 6.6 Information on integration of mental health service

According to trained healthworkers, integration helps in changing attitude of community people towards mental health and illness, as they need not to rely only on traditional healers for treatment. Similarly, many of them expressed that mental health is also a public health problem. Therefore, it is necessary to integrate mental health services into existing health care system. Patients could get this service on time at a very low price in their own community. The numbers of mental patients may increase because of political conflict, poverty, social injustice and discrimination. The availability of mental health service at the health post is helpful in reducing the stigma against mental illness because awareness can be increased in the society.

Health workers provided integration options like seen in other health services i.e. TB, MCH etc, coordinating with HMG and developing regular plans. It is necessary to provide mental health training to all the health workers, make affordable availability of mental health drugs in health facilities, provide regular service for mental patients rather than fixing certain clinic days in health post and increasing mental health awareness. Similarly, regular supervision is necessary to strengthen the integration and capacity of health workers in mental health.

The major problem in integration is that HMG has given low priority to mental health services. But the mental health situation of the country is equally as problematic as other health problems. Increased number of mental health problems in the country obviously demand greater amount of services from the nation, which otherwise is not possible because of limited availability of mental health experts in the country. Consequently, integration of mental health service in the existing health service system is the only viable option, which has been proved and at present seems to be feasible system in the form of the community mental health service in the western region of the country.

Untrained health workers also suggested establishing a separate mental health section in the district health office to coordinate and run mental health services in the district smoothly. The benefit, while providing mental health services from the health post seems to be much more valuable than the risk. Vast majority of the people from rural and urban area will get this service at a cheaper price in their own community. It helps in reducing stigma against mental illness. The current health manpower and physical structure of the health post can be utilized for this service as well, so it will be cost effective for government as well. In addition, this structure facilitates mentally ill people to be treated in their own community and helps in rehabilitation of mental patients in their own family and community.

The integration of mental health care into general health services, particularly at the primary care level, has many advantages. These includes: less stigmatization of patients



and staff, as mental and behavioral disorders are being seen and managed alongside physical health problems; improved screening and treatment, in particular improved detection rates for patient presenting with vague somatic complains which are related to mental and behavioral disorders; the potential for improved treatment of the physical problems of those suffering from mental illness, and vice versa; and better treatment of mental aspects associated with "physical" problems. For the administrator, advantages include a shared infrastructure leading to cost-efficiency savings, the potential to provide universal coverage of mental health care, and the use of community resources which can partly offset the limited availability of mental health personnel (WHO, 2001).

Integration requires a careful analysis of what is and what is not possible for treatment and care of mental problems at different levels of care. For example, early intervention strategies for alcohol are more effectively implemented at the primary care level, but acute psychosis might be better managed at a higher level to benefit from the availability of greater expertise, investigatory facilities and specialized drugs. Patient should then be referred back to the primary level for ongoing management, as primary health care workers are best placed to provide continuous support to patients and their families.

The specific ways in which mental health should be integrated into general health care system will to a great extent depend on the current function and status of primary, secondary and tertiary care levels within a countries' health system. According to WHO, to make integration success the following recommendations were given to a policy makers (WHO, 2001):

- General health status must have knowledge, skills and motivation to treat and manage patients suffering from mental disorders.
- There need to be sufficient numbers of staff with the knowledge and authority to prescribe psychotropic drugs at primary and secondary levels.
- Basic psychotropic drugs must be available at primary and secondary care levels.
- Mental health specialists are required to provide support to and monitor general health care personnel.
- Effective referral links between primary, secondary and tertiary levels of care need to be in place.
- Funds must be redistributed from tertiary to secondary and primary levels of care or new funds must be made available.
- Recording systems need to be set up to allow for continuous monitoring, evaluation and updating of integrated activities.

Findings from the current study also support the suggestions of WHO. Health workers, patients and community people equally raised voices regarding the basic requirement to integrate mental health service into existing health care system. The integration of mental health services is essential because of increasing rates of mental health problems, which substantially increases the burden of life to the individual, family and nation as a whole. Mental illness limits the productivity and creativity of an individual in various ways. It directly affects the socioeconomic status of such patient and their families.



The lack of awareness and high stigma against mental illness strongly affects individual, social and economical life of the sufferers. Because of social stigma, the sufferers or families do not tell many about their mental illnesses otherwise they may be neglected or excluded from social activities. Modernization process or social change equally contributes to increased mental health problems as people who do not have adequate coping abilities with strain and stress of daily life situation can become victims of anxiety. The rapid disintegration of the existing social structure in Nepal directly affected by the current internal political conflicts in the country threats to individual security. Hence there are evidences of increased anxieties, depression and other emotional and behavioral problems in a large number of people in the country. So it further highlights the need for mental health services in the grass root level.

## **6.7 Information on recording and reporting system**

Majority of the trained health workers accepted the current recording and reporting systems in mental health, however there were suggestions to modify the existing recording system. Some health workers have to complete many forms which was often not possible because of large numbers of patient presenting to the OPD. It would be better to develop a register book printed alphabetically with all the required headings from central level and distribute to all health posts, a good recording system would aid the integration of mental health services.

Health workers were equally aware about the benefits of recording and reporting systems in mental health. The obvious benefit of recording and reporting system is in evaluating the service and for supervision purposes so that patient gets added benefits. Control group health workers were also aware in same way as the experimental group regarding the benefit of recording and reporting system in mental health. Similar suggestions were provided by the control group health workers such as development of separate register book for mental health because there is no enough space to record mental health information in the existing HMIS (Health Management Information System) form. They also suggested that more headings could be created in HMIS form to facilitate recording of mental health information.

## **6.8 Information from community focus group discussion**

Community people from both group i.e. community where mental health service is available and where not were involved in the discussion on various aspects of mental health. It was designed to assess the impact of awareness raising activities in mental health. Both groups retained almost same concept in the definition of health (table 1). They equally emphasized that being free from any kind of illness and maintained hygiene is health. The difference has been found in defining mental health. Community people who were using mental health service defined mental health from broader perspective of adjustment to daily life such as personal, family and social. People from the area where mental health service was not available, defined mental health (table 2) more in an isolated function of daily life adjustment such free from tension, anxiety, peace mind etc.



Some of the participants in both groups were not able to define mental health properly reflecting further need of awareness raising activities in mental health in the community.

Regarding the cause of mental illness both group (table 3) during discussion raised biological, psychological and social factors to be responsible for it. They explained it with their experiences in daily life, what they had heard from others or read in newspaper, radio etc. They did not attempt to create relationships with cause and effect because they were not known about it. Some of them explained the cause of mental illness in a more colloquial term. Similarly, some people do believe on supernatural power as a strong cause of mental illness. Hence treatment approach to mental illness also determined by such believes such as seeking traditional healers help to nullify the influences of deities. This is much more because of the existing fatalistic attitude to mental illness as supernatural forces may influence only to those person who had bad fate or luck turns against (*'dindasha-la^geko'*). Women were much more prone to explain the phenomena using fatalistic attribute than men were (Bennet, 1983). It is equally true in mental health as well.

Treatment availability information on mental health showed clear gap of information between two groups. None of participants from control group could tell the near places of service availability while participants in other group (experimental) told that basic treatment is available at health post. It is also supported by the earlier findings (Adhikari et al, 2000 a) of south Lalitpur, Rupendehi and Myagdi districts. The real need of awareness raising has not yet reached to vast majority of people living in the community even in the area where mental health service is implemented. Various reasons can be postulated such as population coverage issue of awareness activities, duration since when such activities run, what methods were used to disseminate such information etc.

Information on signs and symptoms of mental illness, participants from experimental group were rightly able to list various types of mental illness such as psychosis (*'boulaha'*), epilepsy, hysteria (dissociative disorder), mental retardation, and alcohol or substance abuse disorder. Participants from control group explained only psychosis (*'boulaha'*), epilepsy, mental retardation and scholastic difficulties in children. Both group participants were rich with vocabulary to explain psychosis and epilepsy than other mental illness. Some of the participants have used indigenous word or name of illness in local language in some part of western region of Nepal. The better knowledge on the signs and symptoms than any other area of mental health in both group participants could be because of their experiences with mentally ill patient in their community. This finding is similar with earlier findings (Adhikari et. al, 2000 a, b) where community people of Rupendehi and Myagdi districts were interviewed. They agreed about their experiences with mentally ill patient. Community people had experiences with mentally ill patient such as psychosis, epilepsy and depression. Family problems, alcohol, husband second marriage and economic problems were the causes of mental illness, mentioned by the community people in focus group discussion. It indicated that mental health problem are common.



Community people, made the following suggestions to mental health: need of trained manpower in mental health, free supply of mental health drugs, availability of mental health service from health post (control community) or continuity of current mental health service (experimental group), supervision from mental health specialist, awareness in mental health and improve healthpost management. Community people raised the valid concern regarding the suggestion, which indicates their keen interest on this service. It is similarly reflected in the earlier research (Adhikari et al, 2000 a, b). It is good strength if can be utilized for sustaining mental health service through local participation as like other nonhealth program in development such as forestry.

Community people from the place where mental health service is available were aware regarding the inappropriateness of behavior shown towards mental patient by society. They suggested further awareness activities needed to diminish the prevailed negative attitude, social and family discrimination. Similarly, people in control group were only mentioned about the responsibility to be taken by family on basic care such as food, medicine, and timely follow up. They did not raised much voice regarding the existing misbehavior shown to mental patient by the community or family. Both group of people were not very aware regarding the rights of mental patient and need of mental health law.

The scope of awareness activities in mental health is still valid and essential as well to make mental health program success and known to every body in the community. Both group of community people agreed the role of family in looking after the mental patient in caring of food, medicine, regular follow up, personal hygiene, emotional support and encouragement to be shown to mental patient. Control community harbors the attitude of taking help from traditional healers and follows their instruction regarding how to deal with mental patient. This is not reflected in other group, which might be due to increased level of understanding in mental illness. But it is too premature to take side of this justification, as it has to be supported by further research in large sample.

## **7.0 Summery of the findings**

- The aim of the current study is to find out the impact of the community mental health service in Western Region of Nepal. It is implemented by Mental Health Project, IOM in partnership with UMN Mental Health program.
- Community mental health program in western region aims to develop a model to integrate mental health service in existing health care system. It has mainly 3 components such as capacity building in mental health of health workers working in government health system, awareness raising activities and research in mental health.
- Comparative experimental design has been adopted in this study. Both descriptive (quantitative) and qualitative information were collected from health workers, mental patients and their relative and community people. Experimental group is considered who has received input in mental health from WRCMHP. It comprised



all three clusters of samples such as health workers, patients and community people however control group comprised only health workers and community people who has not received any input from WRCMHP.

- The sample proportion of health workers between experimental and control group was 51: 49 percentages. Male gender has the highest distribution (87.16) in total. AHW have majority in the sample including both group (54%) working mainly in health post and primary health center.
- The difference in work experience, total pre-post test scores and total scores of case study form is statistically highly significant ( $P = .001$  and  $.000$ ) which proves the effectiveness of mental health training on health workers.
- The patient sample has small number of participants ( $n = 23$ ). There is a wide dispersion (range) in duration of illness before attending health post, duration of treatment taken from health post, time taken to travel to the health post from home and waiting time in health post to consult health workers on the first visit. Hence, the means in these variables could not be considered as a representative value.
- Sixty-one percent of patients were female. Educational level ranged from illiterate to class seven. Majority of mental patients (65%) were married. Housewife, as an occupation, had the highest distribution followed by student.
- Qualitative information from patients were analyzed and compared with relevant variables. Diagnosis and treatment of mental patient given by health workers were compared. Results showed significant correlation (agreement) in the diagnosis and treatment of mental patients between health workers (trained) and the supervising psychiatrist. This further proved the efficacy of the training which provided acquisition of necessary skills in trained health workers.
- The impact of awareness activities in mental health were assessed from patient perspectives including finding out how they knew about mental health service in the health post and what their perception was of mental health service provided from health post. Results in those areas were very encouraging. Information from patient relatives (available at the time of interview) is also supportive of patient perspectives.
- Effectiveness of mental health services is proved by the increased demand of the service from the community.
- Patients were suggesting quicker service, (less waiting time to consult) and free and easy supply of mental health drugs from HP/PHC.
- Health workers answered on six different mental case stories. This assessment revealed significant differences between experimental and control group



knowledge. Individual case profiles revealed that epilepsy was diagnosed by both groups of health workers while the remaining five cases were diagnosed more accurately by health workers in the experimental group.

- Qualitative information revealed that mental health services are effective in strengthening capacity of health workers, and making mental health service available in the community which helped in reducing the stigma in mental illness.
- Community people perceived mental health services positively as they were getting service in their community, which reduces economic burden and increases awareness and trust in mental health services within the community.
- Trained health workers were facing problems such as lack of regular supply of drugs, lack of adequate trained man power in mental health, poor patients were unable to buy medicine for their treatment and lack of awareness in mental health.
- Health workers from the control group raised the issue of mental health training to health workers, supervision, supply of mental health drugs and need of awareness raising activities in the community.
- Integration of current mental health program into existing health care system is crucial because most of the health facilities where mental health service is available is still heavily dependent up on the WRCMHP staff to run mental health clinics rather than health workers of health facilities.
- Some participants also suggest establishment of a separate section in the district health office to coordinate mental health service. This integration process has to be initiated by the government. Health workers expressed their cooperation to run mental health services if they received training, clinical supervision, reliable supply of drugs and awareness raising programs.
- Trained health workers, though accepted current recording system, suggested for modification. The suggested insisted it has to be simplified and made easier. The inclusion of more headings in the mental health section of the current HMIS form was also suggested for uniformity of the program. It also facilitates in the integration of mental health service within the current framework.
- Findings from community focus group discussions showed that community people were aware regarding the need of mental health services in the health post. However, the belief and attribution systems were still heavily influenced by traditional beliefs, which creates barrier in accepting a modern health service. So the need of awareness is still valid.



## **8.0 Conclusion of the study**

Community Mental Health Program in Western Region was run by Mental Health Project, IOM in partnership with Mental Health Program, UMN. The program was implemented in different phases, it started from a single district to most of the districts of the western region by the time of the final phase. Training in mental health for primary health workers, supervision for trained health workers from psychiatrist, and awareness raising activities in mental health programs were the main strategic approach to integrate mental health programs into the existing health care system. It was the aim of MHP, IOM and UMN to develop a model program to integrate mental health service in to existing health care service.

Health workers, both trained and untrained in mental health, community people and mental patients receiving treatment from health post were included in study. Participants who benefited from community mental health programs were categorized as experimental group while other groups who do not have access to such services, were categorized as control group.

Findings of the study proved mental health services in the primary health care system were possible if mental health training to health workers and supervision were provided. Health workers were skillful in identifying and treating mental patients. Awareness in mental health is equally as essential to increase health service seeking and utilizing attitude among public. Though the community mental health program is effective, the long-term sustainability could not be assured due to challenge regarding integration. Health workers, community people and mental patients unequivocally raised the need of mental health service in HP / PHC. Health workers were suggested that the national level priorities in health should focus on mental health needs and services. Further research can be directed to explore these issues.

## **9.0 Recommendation of the study**

The finding of this impact study directs following recommendations to ensure the continuity of mental health program at the grass root level.

- Mental health service can be provided from the existing health care system. Basic mental health training, clinical supervision, awareness raising and provision of supply of mental health drugs are essential components to make the service effective and sustainable.
- Awareness raising activities has to be continued to increase health service seeking behavior in mental health.
- Mental health problems are equally prevalent in the village and patients were attending primary health care centers and health post for service. So, it is essential to include mental health service in the primary health care system.

- Mental health programs at the grass roots level would be better to implement by HMG following the model provided by MHP, IOM and UMN, MHP.

## 10.0 Limitation of the study

- The limitations of this study were related to small sample size of health workers, mental patients and the relatives interviewed. So the findings are limited from generalization. Patient reports card from health post have not been analyzed properly which could provide more information about the recording and reporting systems in mental health service.
- Assessment of sustainability part evaluated only from the perspective of integration issue.
- Informational bias from the participant may have affected the results. If the participants were not interested or less sincere to the study purpose, the information may not represent the real scenario. However, an attempt to reduce bias was made through direct field observation and ensuring the cooperation from all participants. The objectives and instructions were explained clearly in Nepali as many times as it was needed until the participants understood.



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## 12.0 Appendices

### Appendix 1

#### IDENTIFICATION INFORMATION FOR HEALTH WORKER

१. अन्तरवार्ता लिएको तिथि : (तारिखमा) .....
२. नाम : .....
३. स्वास्थ्य चौकीको नाम : .....
४. जिल्ला: ..... ५. नगरपालिका/गा.वि.स. ६. वडा नं. ....

७. धर :

- |             |           |
|-------------|-----------|
| १. ब्राह्मण | ९. नेवार  |
| २. क्षेत्री | १०. तामाङ |
| ३. थारु     | ११. राई   |
| ४. मगर      | १२. चौधरी |
| ५. कामी     | १३. ठाकुर |
| ६. दमाई     | १४. अन्य  |
| ७. सार्की   |           |
| ८. गुरुङ    |           |

८. उमेर ..... ९. लिंग : स्त्री/पुरुष

१०. शिक्षा : साधारण
१. एस. एल. सी. भन्दा कम
२. एस. एल. सी.
३. उच्च शिक्षा (कुन तह सम्म अध्ययन गरेको हो) .....

- पेशागत
१. हेल्थ असिस्टेन्ट
२. अ. हे. व.
३. अन्य .....

११. धर्म .....

१. हिन्दु
२. बौद्ध
३. मुसलमान
४. इसाई
५. अन्य

१२. कामको अनुभव: .....

१३. मानसिक स्वास्थ्यमा तालिम लिएको मिति (साल मात्र) .....

१४. मानसिक स्वास्थ्यमा लिएको तालिमको किसिम:

- क) ब्लक ट्रेनिङ
- ख) रिफ्रेशर ट्रेनिङ
- ग) ओरिन्टेशन ट्रेनिङ

तालिमको अवधि .....

## Appendix 2

### A: आन्तरिक मुल्याङ्कन फाराम (Pre-post Test Questionnaire)

नाम :

पि टेट :

पद :

पोस्ट टेट :

निम्न लिखित प्रश्नको अर्गाई राखिएका कोठामा हो (✓) वा होईन (X) चिन्ह लगाउनुहोस् ।

- १। धेरै जसो मानसिक रोगीलाई घरैमा राखी रेखदेख, उपचार गर्न सकिन्छ ।
- २। मानसिक रोगीलाई धेरै लामो समयसम्म टाढा रहेको मानसिक अस्पतालमा राखी उपचार गर्नु पर्छ ।
- ३। भावनात्मक घटना घटेपछि सधैं मानसिक रोग उब्जन्छ ।
- ४। मानसिक रोगीको उपचार र पुनर्स्थापनमा उसको परिवारको महत्वपूर्ण भूमिका हुन्छ ।
- ५। साधारण अस्पताल र स्वास्थ्य चौकीमा पनि मानसिक रोगीको राम्रो उपचार गर्न सकिन्छ ।
- ६। धेरै जसो मानसिक रोगीहरू असाधारण तरिकाले कुरा गर्ने र व्यवहार गर्ने गर्दछन् ।
- ७। मृगी रोग (इपिलेप्सी) भएका बच्चाहरूका बुद्धि साधारणतया कमजोर हुने भएकोले उनीहरूले पढ्न सक्दैनन् त्यसैले स्कूल पठाउनु हुँदैन ।
- ८। मानसिक स्वास्थ्य सम्बन्धी केही तालिम पाएका नर्स र अन्य स्वास्थ्य कर्मीहरूले मानसिक रोगीको उपचारशुरु गर्न र तिनीहरूको अनुकरण (फलोअप) गर्न सक्दछन् ।
- ९। साधी-भाइहरूको दबाव लागुपदार्थ प्रयोगको प्रमुख कारण हो ।
- १०। हस्तमैथुन (मास्टर्बेसन) गर्दा मानसिक रोग हुन सक्छ ।
- ११। सुस्त मनस्थिति (मेन्टल रिटाड्रेसन) हुने अवस्थालाई कहिले पनि रोक्न सकिँदैन ।
- १२। बच्चा जन्मदा भएका कम्लिकेशनहरूबाट इपिलेप्सी हुन सक्छ ।
- १३। सुस्त मनस्थिति भएका बच्चाहरूको रेखदेखमा आमा बाबुको भूमिका कमै रहन्छ ।
- १४। सुस्त मनस्थिति भएका बच्चाहरूलाई खास प्रकारको औषधी प्रयोग गरेर उनीहरूको बुद्धि (इन्टेलिजेन्स) बढाउन सकिन्छ ।
- १५। गर्भावस्थामा भएका बेलामा आयोडिनको कमि भएमा त्यस आमाले जन्माएको बच्चा सुस्त मनस्थिति हुन सक्छ ।
- १६। निदाएको अवस्थामा हिस्टेरिकल फिट्स (छारे रोगमा जस्तो लाग्ने) हुँदैन ।
- १७। धेरै प्रकारका शारीरिक रोगहरूले गर्दा एकदुट अर्गानिक साइकोसिस हुन सक्दछ ।
- १८। कुनै बिरामीले आफूलाई धेरै प्रकारका लक्षणले पिरोलिएको बताउँछन् र ती लक्षण अनिश्चित छन् चर्चे उसलाई मानसिक रोग भएको छ भनी शंका गर्नुपर्छ ।
- १९। निश्चित मात्रा भन्दा बढी मात्रामा एमिटिप्टिलिन खाएमा खतरनाक हुन्छ ।



- (२०) इपिलेप्सीको उपचारमा साधारणतया विभिन्न औषधी मिसाएर (पोलिड्रग थेरापी) उपचार गर्नुपर्छ।
- (२१) कुनै विरामीले म आत्महत्या गर्ने विचारमा छु भन्दछ भने त्यसलाई वास्ता नगरे पनि हुन्छ किनकी उसले अरुलाई तर्साएर नाजायज फाइदा लिन खोजेको हुन्छ।
- (२२) यदि कुनै प्रौढ व्यक्ति (एडल्ट) लाई इपिलेप्सी भयो भनी निदान (डायाग्नोसिस) गरेको छ भने दिनको ६० मिलिग्राम फिनोबार्बिटोन शुरु गरे राम्रो हुन्छ।
- (२३) डाएजोपाम र यस ग्रुपका अन्य आपधीले मानिसलाई अम्मली (डिपेन्डेन्ट) बनाउँदछ।
- (२४) स्वास्थ्य चौकीको तहमा साइकोसिस भएको (बौलाहा) नयाँ विरामी आएमा प्रति दिन ४०० मिलिग्राम क्लोरप्रोमाजिन शुरु गर्नु पर्छ।
- (२५) एर्माट्राप्टालिन भन्ने औषधीले बुढाबुढीमा पिसाब खुन्न नदिने (रिटेन्सन अफ युरिन) गर्दछ।
- (२६) स्वास्थ्य चौकीबाट निम्न विरामीलाई जहिले पनि रिफर गरेर अस्पतालमा पठाउनु पर्छ।
- (क) स्टार्टस इपिलेप्टक्स
- (ख) आत्महत्याको प्रयत्न गरेको (सुसाइड एटेम्प्ट)
- (ग) स्टार्टस इपिलेप्टक्स
- (२७) आत्महत्याबारे निम्न कुरा सत्य हुन्।
- (क) विरामीसंग आत्महत्याको विचार मनमा आएको छ कि सोध्नु पर्छ।
- (ख) आत्महत्या गर्ने धेरै जसो विरामीले आत्महत्याको कुरा गर्दैनन्।
- (२८) तलका प्रश्नहरूमा मिल्ने कुराहरूको जोडा मिलाउनुहोस्।
- (क) निम्न औषधीहरू कुन कुन ग्रुपको औषधीमा पर्दछन्।
- |                         |                          |
|-------------------------|--------------------------|
| (ए) एर्माट्राप्टालिन    | एन्टीपार्कीन्सोनियन ड्रग |
| (बी) डाइजोपाम           | एन्टीडिप्रेसाइन्ट ड्रग   |
| (सी) फेनाबार्बिटोन      | एन्टीसाइकोटिक ड्रग       |
| (डी) ट्राइहेक्सीफेनाइडल | एन्टीकन्भलसेन्ट ड्रग     |
| (इ) क्लोरप्रोमाजिन      | एन्टी एंजाइटी ड्रग       |
- (ख) कुन लक्षण देखा पर्दा निम्न रोग हुन्छन्।
- |                           |   |
|---------------------------|---|
| (ए) डिप्रेसन              | इनएप्रोपिएट मुड   |
| (बी) हिस्टेरिकल न्युरोसिस | गिल्टी फिलिङ (आफूलाई दोषी मान्ने)                       |
| (सी) साइकोसिस             | डिलेड माइलस्टोन   |
| (डी) मेन्टल रिटाडेसन      | एक्सोसिभ स्वेटिङ  |
| (इ) एंजाइटी न्युरोसिस     | पोसेसनबाई स्प्रिट (भूत, प्रेत, पिचास मसान वेउता लाग्नु) |

## B: Case Evaluation Form

(कृपया यो पत्र फिर्ता गर्नु होला )

तलका लक्षणहरु राम्रोसँग पढ्नुहोस् र तल दिइएका नौ वटा प्रश्नको उत्तर लेख्नुहोस् ।

बिरामी नं. १

१. एकजना १५ वर्षकी केटी आमासँग आउँछिन् ।
२. ४ महिनाका लक्षणहरु लिएर ।
३. ४ महिना देखि यता ६ पटकसम्म एककासी बेहोश भएकी र एक पटक बेहोश हुँदा ५ देखि १५ मिनेटसम्म बेहोश हुने गरेकी ।
४. ७ पटक मध्ये २ पटक बेहोश हुँदा उनलाई चोट-पटक लाग्यो ।
५. बेहोश भएर उठेपछि एक दिनसम्म टाउको दुखेको गुनासो गरिँन् ।
६. कुनै कुनै पटक बेहोश हुँदा उनले जिन्नो टोकेकी थिइन् ।
७. उनको हात-खुट्टा बेहोश भएको बेलामा तनक्क तन्किएका र हल्लिएका थिए ।

बिरामी नं. २

१. बीस वर्षकी केटी
२. उनको विवाह एक वर्ष अघि भयो तर आफ्नो श्रीमान्लाई मन पराइनन् ।
३. एक वर्ष देखि यता उनी घरी-घरी टाउको दुखेको, कमजोर भएको र खान रुची नभएको गुनासो गरिँन् ।
४. ४ महिना पहिले, जब उनको श्रीमानले उनलाई गाली गरे त्यसबेला उनी बेहोश भईन् र मानिसहरुले उनलाई भूत लाग्यो भनेर भने ।
५. आज भोलि उनी बा-आमाको घरमा बस्छिन् र आफ्नो श्रीमानसँग बस्न अस्वीकार गरिँन् । उनको बा-आमाको घरमा उनलाई माथिका लक्षणहरु देखा पर्दैनन् ।

बिरामी नं. ३

१. २५ वर्षको कारखानामा काम गर्ने मान्छे ।
२. एक वर्ष पहिले काम गर्दा उसको छाती दुख्यो र ऊ कारखानाको डाक्टर कहाँ गयो ।
३. जाँचसकेपछि डाक्टरले केही पनि भएको छैन भनी केही चर्कीहठी दिए ।
४. पहिलो डाक्टरको सल्लाहबाट विश्वस्त नभएर उसले मुटुको रोगको विशेषज्ञसँग सम्पर्क राख्यो तर उनले पनि मुटुमा केही भएको छैन भनी बताए ।
५. उसको छाती दुखिराख्यो, मुटुको धड्कन पनि बढ्यो र भ्रम कमजोर पनि भयो । ऊ बिचार गर्छ कि डाक्टरले उसको रोग पत्ता लगाउन सकेन । ऊ आफ्नो स्वास्थ्यको बारेमा घरी-घरी चिन्ता गर्छ । राम्रोसँग काम गर्न सक्दैन ।
६. एक वर्ष अघि उसको बा मुटुको रोगले मर्नु भयो ।

बिरामी नं. ४

१. ३६ वर्षको खेतीपातीको काम गर्ने गाउँले (मान्छे) ।
२. तीन महिना अघिदेखि ऊ धेरै कुरा गर्न लाग्यो । उः भन्छ कि म जमिन्दार हुँ र एकदम धनी मान्छे पनि हुँ ।
३. ऊ काम गर्दैन र खालि गाँउमा डुल्छ र सबै मानिससँग नचाहिदो किसिमले गफ मात्रै गर्छ ।
४. आजभोलि उसको छिटो रिसाउने बानी छ, उसमो सल्लाह नमाने देखि अरु मानिसलाई गाली गर्छ । एक हप्ता अघि उसको छिमेकीसँग विना कारण झगडा गर्न शुरु गर्‍यो ।
५. खाना नमीठो भयो भनेर ऊ आफ्नी श्रीमतलाई गाली गर्छ तर अरु मानिसहरु भन्छन् उनले पकाएको खाना एकदम मीठो हुन्छ । आजभोली उसलाई राम्रोसँग तिन्द्रा पनि पर्दैन ।
६. २ वर्ष अघि उसलाई यस्तै किसिमको रोग लागेको थियो र ४ महिना भित्र ऊ पूर्ण रूपले बिसक भएको थियो ।

बिरामी नं. ५

१. ४५ वर्षकी स्वास्नीमान्छे ।
२. २ वर्ष अघि उनको मैनावारी रोकियो ।
३. साथै २ वर्ष अघिदेखि यता दैनिक काममा रुची देखाउँछिन्, जिऊ पोल्थो, सिल्का हान्थो, भ्रमभ्रम गर्‍यो, दुख्यो र कमजोर भयो भन्छिन् । उनी एकलै एकै ठाउँमा बस्न रुचाउँछिन् ।



४. धेरै जसो उनी रोइ रहन्छिन र मन निको भन्छन् । उनलाई तिन्द्रा राधोगरी पढिन र खाना पनि मीठो लाग्दैन ।
५. घरी-घरी उनी रिस्वाउँछिन् र छोराहरूले भलाई हेला गर्छन् भन्छिन् तर अरु मान्छेहरूलाई उनीहरू आमालाई एकदम माया गर्छन् भन्ने कुरा थाहा छ ।

विरामी नं. ६

१. १७ वर्षकी दशौ कक्षामा पढ्दै गरेकी विद्यार्थी ।
२. आठौ कक्षामा उनी पहिला भइन् तर त्यस पछिका परीषाहरूमा धेरै नम्बर पाउन थालिन् ।
३. आजभोलि उनी एकलै बस्न मन पराउँछिन् अरु बसेको ठाउँमा बस्न चाहँदैनन् ।
४. उनको वारेमा अरु मानिसहरू तराम्रो कुरा गर्छन्, उनको कुरा काट्छन् भन्ने विश्वास गर्छिन् तर वास्तवमा यसो होइन ।
५. कुनै कारण बिना नै कहिले काही उनी आफैँ एकलै कुरा गर्छिन् र हाँसिन्छन् ।
६. कहिले काही उनको व्यवहार यस्तो हुन्छ कि उनले के गरेकी भन्ने कुरा कसैले पनि बुझ्न सक्दैनन् ।

सहभागीको नाम .....

विरामी नं.

१. यो मानसिक रोग हो कि ? हो । होइन । थाहा छैन ।
२. तपाईंले माथिको लक्षणहरू पढेपछि कुन रोगको विरामी भएको थाहा पाउनु भयो ?  
.....
३. त्यही रोग हो भन्नको लागि कुन कुन आधारहरू छन् ? लेख्नुहोस् ।  
(क) ..... (ख) .....  
(ग) ..... (घ) .....
४. तपाईं यो विरामीलाई आफ्नो कित्तिभन्दा उपचार गर्न सक्नुहुन्छ ? हो । होइन ।
५. यदि तपाईं सक्नु हुन्छ भने कुन औषधी, कति मात्रा (डोज) दिनु हुन्छ ?  
..... डोज .....  
..... डोज .....
६. तपाईंले यो औषधी दिए पछि त्यो औषधीको कुन कुन तराम्रो असर पर्न सक्छ र तराम्रो असर परेको खण्डमा कसरी उपचार गर्नु हुन्छ ?  
(क) .....  
(ख) .....  
(ग) .....
७. तपाईंले औषधी खानको लागि कति अवधिसम्म सल्लाह दिनु हुन्छ ?  
.....
८. तपाईं विरामीलाई अथवा विरामीको परिवारलाई अरु केहि खास सल्लाह दिनु हुन्छ ? लेख्नुहोस् ।  
(क) .....  
(ख) .....  
(ग) .....
९. छ महिनाको अन्त्यमा यो रोगको परिणाम कस्तो जस्तो हुन्छ ?  
(क) त्यो रोगको कुनै लक्षण देखिदैन ।  
(ख) त्यो रोगको अलि अलि लक्षणहरू बाकि रहन्छन् ।  
(ग) सामान्य प्रगति  
(घ) रोगको लक्षणमा परिवर्तन आउँदैन ।  
(ङ) रोगीको अवस्था भन् विग्रने छ ।  
(च) थाहा छैन ।

४. धेरै जसो उनी रोइ रहन्छीन र मन निको भन्छिन् । उनलाई निन्दा राम्रोगरी पढेन र खाना पनि मीठो लाग्दैन ।
५. घरी-घरी उनी रिमाउँछिन् र छोराहरूले मलाई हेला गर्छन् भन्छिन् तर अरु मान्छेहरूलाई उनीहरू आमालाई एकदम माया गर्छन् भन्ने कुरा थाहा छ ।

विरामी नं. ६

१. १७ वर्षकी दगौ कशामा पढ्दै गरेकी विद्यार्थी ।
२. आठौ कशामा उनी पहिला भइन् तर त्यस पछिका परीपाहरूमा धेरै नम्बर पाउन थालिन् ।
३. आजभोलि उनी एकै बस्न मन पराउँछिन् अरु बसेको ठाउँमा बस्न चाहँदैनन् ।
४. उनको बारेमा अरु मानिसहरू नराम्रो कुरा गर्छन्, उनको कुरा काट्छन् भन्ने विश्वास गर्छिन् तर वास्तवमा यस्तो होइन ।
५. कुनै कारण विना नै कहिले काही उनी आफैँ एकै कुरा गर्छिन् र हाँस्छिन् ।
६. कहिले काही उनको व्यवहार यस्तो हुन्छ कि उनले के गरेकी भन्ने कुरा कसैले पनि बुझ्न सक्दैनन् ।

सहभागीको नाम .....

विरामी नं.

१. यो मानसिक रोग हो कि ? हो । होइन । थाहा छैन ।
२. तपाईंले माथिको लक्षणहरू पढेपछि कुन रोगको विरामी भएको थाहा पाउनु भयो ?  
.....
३. त्यही रोग हो भन्नेको लागि कुन कुन आधारहरू छन् ? लेख्नुहोस् ।  
(क) ..... (ख) .....  
(ग) ..... (घ) .....
४. तपाईं यो विरामीलाई आफ्नो क्लिनिकमा उपचार गर्न सक्नुहुन्छ ? हो। होइन ।
५. यदि तपाईं सक्नु हुन्छ भने कुन औषधी, कति मात्रा (डोज) दिनु हुन्छ ?  
..... डोज .....  
..... डोज .....
६. तपाईंले यो औषधी दिए पछि त्यो औषधीको कुन कुन नराम्रो असर पर्न सक्छ र नराम्रो असर परेको खण्डमा कसरी उपचार गर्नु हुन्छ ?  
(क) .....  
(ख) .....  
(ग) .....
७. तपाईंले औषधी खानको लागि कति अवधिसम्म सल्लाह दिनु हुन्छ ?  
.....
८. तपाईं विरामीलाई अथवा विरामीको परिवारलाई अरु केहि खास सल्लाह दिनु हुन्छ ? लेख्नुहोस् ।  
(क) .....  
(ख) .....  
(ग) .....
९. छ महिनाको अन्त्यमा यो रोगको परिणम कस्तो जस्तो हुन्छ ?  
(क) त्यो रोगको कुनै लक्षण देखिदैन ।  
(ख) त्यो रोगको अलि अलि लक्षणहरू चाँफि रहन्छन् ।  
(ग) सामान्य प्रगति  
(घ) रोगको लक्षणमा परिवर्तन आउँदैन ।  
(ङ) रोगीको अवस्था भन् विषयमा छ ।  
(च) थाहा छैन ।



## Appendix 3

### Attitude Questionnaire for Health Staff Trained in Mental Health

१. तपाईंको विचारमा मानसिक स्वास्थ्य सम्बन्धी तालिम तथा कार्यक्रमले तपाईंको काममा कस्तो परिवर्तन ल्याएको छ ?
- (क) पटककै परिवर्तन ल्याएको छैन  
(ख) शिप तथा क्षमतामा केही परिवर्तन ल्याएको छ ।  
(ग) शिप तथा क्षमतामा सामान्य परिवर्तन ल्याएको छ ।  
(घ) मानसिक बिरामीको निदान तथा उपचारमा राम्रो मद्दत गरेको छ ।  
(ङ) मानसिक बिरामीको निदान तथा उपचारमा एकदमै राम्रो मद्दत पुऱ्याएको छ ।
२. तपाईंको विचारमा मानसिक स्वास्थ्य सम्बन्धी तालिमले स्वास्थ्य केन्द्रमा काम गर्न कसरी मद्दत गर्दछ ?
३. तपाईंको विचारमा मानसिक स्वास्थ्य सेवा स्वास्थ्य केन्द्रबाट प्रदान गर्दा समुदायमा कस्तो असर पर्छ ?
४. तपाईंको विचारमा मानसिक समस्यालाई उपचार गर्ने औपधी बाहेक अरु तरीकाहरु के के हुन सक्छन् ?
५. तपाईंको विचारमा यस स्वास्थ्य केन्द्रबाट उपलब्ध गराइएको मानसिक स्वास्थ्य सेवालाले यहाँका समुदायले कसरी बुझेका छन् ?
६. तपाईंको अनुभवमा मानसिक स्वास्थ्य सेवा स्वास्थ्य केन्द्रबाट प्रदान गर्दा आउने कठिनाईहरु के के हुनसक्छन् ?
७. तपाईंको विचारमा के मानसिक स्वास्थ्यमा सेवामा अनुगमन (Supervision) गर्नु आवश्यक छः
- छ                      छैन  
किन ?
८. तपाईंको विचारमा कसरी अनुगमनले (Supervision) यस क्षेत्रमा शिप अभिवृद्धि हुन्छ ?
९. तपाईंको विचारमा के मानसिक स्वास्थ्य सेवालाले अहिलेको स्वास्थ्य संरचनामा एकिकृत गरेर लैजानु आवश्यक छ ?
- छ                      छैन  
किन ?  
यदि छ भने कसरी एकिकृत गर्न सकिन्छ ?
१०. तपाईंको विचारमा मानसिक स्वास्थ्य सेवामा अहिले भई आएको अभिलेख (Recording system) प्रणालीले दैनिक काममा मद्दत पुऱ्याएको छ ?
- छ                      छैन  
किन ?  
यदि छ भने कसरी ?  
यदि छैन भने किन ?
११. तपाईंले मानसिक स्वास्थ्य सेवाको Record को Reporting गर्ने गर्नुहुन्छ ?
- हो                      होइन  
यदि हो भने कुन निकायमा रिपोर्टिङ्ग गर्नुहुन्छ ?

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## Appendix 4

### Attitude Questionnaire for Health Staff Control Group

१. के तपाईं स्वास्थ्य केन्द्रबाट मानसिक विरामीलाई पनि सेवा प्रदान गर्नुहुन्छ ?  
हो होइन  
किन
२. यदि प्रदान गर्नुहुन्छ भने, मानसिक रोगीहरु कति मावामा सेवाको लागि आउने गर्दछन् ?  
क) प्रत्येक दिन १ - ३ जना  
ख) हप्तामा १ - ३ जना  
ग) १५ दिन १ - ३ वा बढी  
घ) महिनामा १ - ३ वा बढी
३. यदि मानसिक रोगीलाई सेवा प्रदान गर्नु भएको छ भने के कस्ता कठिनाईहरु अनुभव गर्नु भयो यस्ता रोगीहरुको उपचारमा ?
४. यदि सेवा प्रदान गर्नु भएको छैन भने मानसिक स्वास्थ्य सेवा स्वास्थ्य केन्द्रबाट प्रदान गर्दा आउन सक्ने चुनौति (कठिनाई) हरू के के हुन् सक्छन् ?
५. तपाईंको विचारमा मानसिक स्वास्थ्य सेवा कसरी स्वास्थ्य केन्द्रबाट प्रदान गर्न सकिन्छ होला ?
६. के तपाईंको कार्यक्षेत्रमा मानसिक स्वास्थ्य सेवा आवश्यक छ ?  
छ छैन  
यदि छ भने किन ?
७. के तपाईंको विचारमा मानसिक स्वास्थ्य सेवालार्इ अरु स्वास्थ्य सेवाका कार्यक्रमहरु जस्तै (मातृ शिशु सेवा, टि.बी. कार्यक्रम) अहिलेको स्वास्थ्य संरचनामा एकिकृत गरेर लैजानु आवश्यक छ ?  
छ छैन  
किन ?  
यदि छ भने कसरी एकिकृत गर्न सकिन्छ ?
८. तपाईंको विचारमा मानसिक स्वास्थ्य कार्यक्रम स्वास्थ्य केन्द्रबाट सञ्चालन गरेमा अरु कार्यक्रम जस्तै अनुगमनको आवश्यकता पर्दछ कि पर्दैन ?  
पर्छ पर्दैन  
किन ?
९. तपाईंको विचारमा मानसिक स्वास्थ्य सेवा स्वास्थ्य केन्द्रबाट सञ्चालन गर्दा अभिलेख (Recording system) आवश्यक छ ?  
छ छैन  
किन  
यदि छ भने कसरी अभिलेख राख्न सकिन्छ ?

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## Appendix 5

### Patient examination Record

Identification Information:

Patient Number:

Date:

Patient Name (Full Name):

Age:

Sex:

Education:

Marital Status:

Address:

Name of the Health Post:

Occupation:

---

A. Reason for consultation in health center in the past:

B. Diagnosis made in health center in earlier visit:

C. Treatment suggested from health center in earlier visit:

Medicine:

Counseling:

Side effect of the medicine, if any.....

D. Remarks (current evaluation).

Diagnosis:

Treatment:

Signature of the consultant

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## Appendix 6

### विरामी अन्तरवार्ता फर्म 'ए'

मिति:

नाम:

उमेर:

लिङ्ग:

ठेगाना:

उपचार गरेको स्वास्थ्य केन्द्रको नाम:

अन्तरवार्ता लिने व्यक्तिको नाम:

कृपया तल दिइएको प्रश्नहरू राम्रोसँग पढेर जवाफ दिनु होला । तपाईंको उत्तरले मानसिक स्वास्थ्य सेवालालाई अझ राम्रो पार्न अत्यन्त महत्वपूर्ण हुन्छ । त्यसैले सबै प्रश्नहरूको उत्तर दिनु भई सहयोग गर्नु हुन अनुरोध गर्दछु ।

१. तपाईं यो स्वास्थ्य संस्थामा उपचारको लागि आउनु भएको कति भयो ? ( महिना वा वर्षमा लेख्नु/लेख्नुस् )
२. तपाईं आफूलाई मानसिक रोग लागेको कति समयपछि यस स्वास्थ्य संस्थामा आउनु भयो ?
३. तपाईंले यहाँ मानसिक रोगका ( तपाईंको समस्या ) उपचार हुन्छ भनेर कसरी थाहा पाउनु भयो ?
४. शुरुमा यस स्वास्थ्य केन्द्रमा जचाउने आउंदा ( कसरी ) आउनु भयो ? जस्तै एकलै, परिवारका सदस्यले लिएर आएको वा अन्य ..... ।
५. पहिलो पटकको जाँच गराउन स्वास्थ्य केन्द्रमा तपाईंले अन्दाजी कतिबेर कुनै पन्यो ?
६. यो जाँचबाट तपाईंलाई कतिको सन्तुष्ट लाग्यो ?
  - क) एकदमै अनसन्तुष्ट
  - ख) असन्तुष्ट
  - ग) अलिअलि सन्तुष्ट
  - घ) सन्तुष्ट
  - ड) एकदमै सन्तुष्टकिन ?
७. तपाईंलाई यो स्वास्थ्य केन्द्रमा उपचारको लागि आउंदा कति समय लाग्यो ? ( घरबाट यहाँसम्मको बाटो-यात्रा समय )
८. जाँच पश्चात तपाईंलाई आफ्नो रोग बारे स्वास्थ्य कार्यकर्ताले कतिको बुझेको जस्तो लाग्यो ?
९. के तपाईंलाई जाँचपश्चात कुनै औषधी दिएको थियो ?
  - थियो
  - थिएनथियो भने के दिएको हो ? ( विरामीले follow up मा लिएर आउने पुर्जा हेरेर स्वास्थ्य चौकीको record हेरेर लेख्नुहोला ।
१०. यदि औषधी दिएको छ भने तपाईंले यो औषधी नियमित रूपमा सेवन गरी राख्नु भएको छ ?
  - छ
  - छैनयदि छैन भने किन ?
११. जचाउने क्रममा सम्बन्धित स्वास्थ्यकर्ताले तपाईंलाई औषधी खाने तरिकाबारे के भन्नु भएको थियो ?



१२. त्यसैगरी यो औपधीको सम्भावित नकारात्मक असर तथा यसबाट बच्ने उपायबारे केहि भन्नु भएको थियो ?
१३. यो औपधी कति समयसम्म खानु पर्छ भनेर तपाईंलाई भनिएको छ ?
१४. यो औपधी उपचार शुरु गरेपछि नियमित रूपमा स्वास्थ्य चौकीमा सम्पर्क राख्नेबारे केहि बताएको छ ? ( कतिकति समयमा सम्पर्क राख्ने भनेको छ ? )
१५. सम्बन्धित स्वास्थ्य कर्ताले तपाईंको रोग, तथा उपचारको बारेमा तपाईंको परिवारसँग आवश्यक सल्लाह गर्नु भएको छ ? छ भने स्पष्ट पारिदिनुहोस् ।
१६. तपाईंको अनुभवमा अहिले तपाईंलाई आफ्नो समस्यामा सुधार आएको जस्तो लाग्छ ? ( प्रतिशतमा उल्लेख गर्नुहोस् ) ।
१७. तुलनात्मक रूपमा भन्नु पर्दा उपचार अघि र यो उपचार शुरु गरेपछि तपाईंले के के कुरामा फरक अनुभव गर्नु भयो ?

रोगको लक्षणमा:

काम वा पेशा:

पारिवारिक जीवन:

सामाजिक कृयाकलाप:

### फर्म 'बी'

विरामीको नातेदार जो अन्तरवार्ताको समयमा आउँछन् उनीहरूसँग मात्र सोध्ने प्रश्नावली

१. यस स्वास्थ्य केन्द्रमा उपचारको लागि आउन तपाईंको विरामी अष्टयारो मान्नुहुन्छ ?  
 हो होईन  
 यदि हो भने किन ?
२. तपाईंको आफ्नो अनुभवमा यस स्वास्थ्य चौकिबाट मानसिक रोगीहरूलाई प्रदान गरिने सेवा कस्तो छ ?
३. उपचार शुरु गरे पछि तपाईंको विरामीमा केही परिवर्तन आएको छ ?  
 छ छैन  
 छ भने के के परिवर्तन देख्नु भएको छ कृपया स्पष्ट पार्नु होस् । ( जस्तै व्यक्तिगत हेरविचार, कार्यक्षमता, पारिवारिक सम्बन्ध, सामाजिक कृयाकलाप )
४. मानसिक रोगीको पूर्ण उपचार प्रकृत्यामा परिवारका सदस्यको भूमिका कस्तो हुन्छ ?
५. परिवारको भूमिका बारेमा सम्बन्धित स्वास्थ्यकर्मीबाट सल्लाह / सुझाव पाउनु भएको छ ?  
 छ छैन  
 छ भने के स्पष्ट पार्नुहोस् .....

## Appendix 7

### Questions for Community People

1. स्वास्थ्य भन्नाले तपाईं के बुझ्नुहुन्छ ?
2. मानसिक स्वास्थ्य भनेको के हो ? बताउनुोस् ।
3. तपाईंको मानसिक रोगीहरुप्रति कस्तो अनुभव छ ? बताउनुोस् ।
4. के तपाईंलाई आफ्नो गाउँ / टोलमा भएका मानसिक रोगीहरुबारे थाहा छ ? भन्नुोस् ।
5. तपाईंको विचारमा मानसिक रोग के कारणले गर्दा हुन्छ ? भन्नुोस् ।
6. मानसिक रोगीहरुप्रति हामीले देखाउनुपर्ने राम्रो व्यवहारहरु के के हुन सक्छ ?
7. तपाईंको विचारमा मानसिक रोगीहरुप्रति देखाइंदै आएको व्यवहार ठिक छ ? किन ?
8. मानसिक रोगीहरुलाई उपचार गर्ने ठाउँ कहाँ छ ? भन्नुोस् ।
9. मानसिक रोगीहरुलाई राम्रो गर्न के के सुधार गर्नु आवश्यक छ ?
10. मानसिक रोगीहरुलाई उपचारको लागि परिवारको कस्तो भूमिका हुनुपर्दछ ।



24. Diazepam and other similar anti: anxiety drugs may lead to dependence (true or false).
25. Tricyclic antidepressants may cause all except:
- (a) Dry mouth    (b) Blurring of vision    (c) Drowsiness
- (d) Giddiness    (e) Rigidity of muscles.
26. Which of the following is true about suicide (a or b):
- a) It is necessary to ask depressed patients about suicidal ideas.
- b) The majority of suicidal patients do not talk about their suicidal thoughts before they try to commit suicide.
27. The following are always reasons for referring a patients from the health post to a hospital (True or False)
- Psychosis
- Suicidal attempt
- Status Epilepticus
28. At a health post level a new patient with psychosis should be started on chlorpromazine 400 mg. 1 day (True or False)
29. Amitriptyline may cause retention of urine in the elderly (True or False).

## Appendix 9

### TUTORS TRAINING COURSE, TRAINING ASSESSMENT - CLINICAL QUESTIONNAIRE

Please read the clinical description to each history given below, and answer the following questions for each case on the separate sheets provided.

(Do not write anything on this question sheet).

---

#### CLINICAL HISTORY NO. B1

1. 15 years old girl, comes with mother.
  2. Duration of symptoms - 4 years.
  3. Since 4 months had 7 attacks of suddenly becoming unconscious for 1/4 hour or so.
  4. While she was standing, on two such attacks, she had fallen and sustained injuries.
  5. After getting up from the attack, she complains of headache for a day.
  6. During a few attacks, she had bitten her tongue.
  7. All the 4 limbs are reported to shake jerkily during the attacks.
- 

#### CLINICAL HISTORY NO. B2

1. 20 year old girl.
  2. 1 year back, got married to a boy whom she did not like.
  3. Since 1 year, often she is getting headache and always complains of weakness.
  4. 4 months back, when her husband scolded her she fell unconscious and was said to be possessed by a spirit and since then she has had many such attacks.
  5. Now she is in her parent's house and refuses to go to the husband's house. There she is symptom free.
- 

#### CLINICAL HISTORY NO. B3

1. 25 year old farmer.
  2. One year back, he got episode of palpitation, chest pain, while working and immediately went to the health post.
  3. After examination, health assistant said 'nothing wrong' and gave him some tablets.
  4. Being not convinced, he consulted a private doctor who also told him that his heart was in 'good' condition.
  5. But he continues to have episode of chest pain, palpitation, sweating and weakness. He thinks that doctor failed to detect the nature of illness. He always worries about his health.
  6. His father had died due to heart attack one year back.
-



#### CLINICAL HISTORY NO. B4

- 36-year-old villager, works as an agriculture laborer.
  - From 3 months he talks too much. He says that he is a landlord and claims to have lots of money.
  - He does not do any work, wanders in the village, talks to everybody unnecessarily.
  - Of late he is very irritable, scolds people for not taking his advice. A week ago he picked up a quarrel with his neighbor for no good reasons.
  - He abuses his wife with the reason that the food she serves is not tasty, though others say that she cooks well.
  - His sleep is disturbed.
  - He had a similar episode 2 years back and recovered totally within 4 months.
- 

#### CLINICAL HISTORY NO. B5

- 45 year old lady.
  - She attained menopause 2 years ago before which she had irregular menstruation for one year.
  - Since 2 1/2 years she is dull, showing less and less interest in daily activities. She complains of body-ache and weakness and prefers to sit alone in one place.
  - Often she weeps and says that it is better to die.
  - At times she loses her temper and accuses her sons that they are neglecting her. But other knows that her children like her very much.
- 

#### CLINICAL HISTORY NO. B6

- 17 years old girl, S.L.C. student.
- She got first class in 8th standard but later she is getting lower marks in the examinations.
- Now a days she does not mix with others and prefers to be alone.
- She believes that others talk ill of her, but everybody knows that it is not so.
- At times, she talks and laughs to self for no known reasons.
- At times she behaves in such a way that others cannot understand her.

#### CASE HISTORY NO:

- Is the patient mentally ill? Yes/No/Cannot say
- What is the diagnosis? \_\_\_\_\_
- Which are the points in favor of this diagnosis?

- i) \_\_\_\_\_ ii) \_\_\_\_\_  
iii) \_\_\_\_\_ iv) \_\_\_\_\_  
v) \_\_\_\_\_ vi) \_\_\_\_\_

4. Can you manage this case in your center ? Yes/No

5. If yes, what drugs you will prescribe and in what dose ?

\_\_\_\_\_ dose \_\_\_\_\_  
\_\_\_\_\_ dose \_\_\_\_\_

6. What side effects do you expect and how would manage them ?

- i) \_\_\_\_\_  
ii) \_\_\_\_\_  
iii) \_\_\_\_\_  
iv) \_\_\_\_\_

7. How long do you advise medication ?

8. What specific advice will you give to the patient or to the family members ?

- i) \_\_\_\_\_  
ii) \_\_\_\_\_  
iii) \_\_\_\_\_

9. What is the prognosis of this case at the end of 6 months ?

- a) Totally symptom free      b) A few residual symptoms present  
c) Moderate improvement      d) Status-quo no change  
e) Condition become worse      f) Cannot say



## Appendix 10

### Attitude Questionnaire for Health Staff Trained in Mental Health

1. What kind of changes brought by the mental health training in your work ?
2. In your opinion how mental health training can facilitate in your work at health center ?
3. In your opinion what impact can occur to community when we provide mental health services through health center
4. In your opinion what other treatment methods except drug treatment are available ? list .
5. In your opinion how people perceive community mental health program and mental health services provided by this health center ?
6. In your experience, what are the barriers you experienced when we provide mental health service through health center
7. What is your opinion about the supervision system in mental health ?
8. Do you think supervision is mental health enhance your working skills ? how ?
9. In your opinion, do you think mental health service need to integrate in the current health system of the community ?

Why ?

If yes how integration can be done ?

10. Do you think the current recording system in mental health service is useful in your work ?

Yes

No

If yes how ?

If no why ?

11. Do you report mental health activity record to related authority?

Yes

No

## Appendix 11

### Attitude Questionnaire for Health Staff Control Group

1. Do you provide mental health service also ?  
Yes  
No  
Why ?
2. If yes, how frequent mentally ill patient visits to your center ?
3. if you are treating mentally ill patient what are the difficulties you have experienced while providing services to such patient ?
4. If not, what are the possible difficulties / challenges we need to face while running mental health service ?
5. In your opinion, how mental health service can render through the health-post level ?
6. Do you think mental health service is necessary in your working area ?  
Yes  
No  
Why ?
7. Do you think mental health service like other services such as MCH, TB Program, needs to be integrated with the existing health system ?  
Yes  
No  
Why ?  
If yes, how integration can be done ?
8. In your opinion, if mental health service is started from the health post, do you think supervision is necessary ?  
Yes  
No  
Why ?
9. Do you think recording system is necessary if mental health service is provided by health post ?  
Yes  
No  
Why ?  
If yes, how we can keep the recording of such program ?



## Appendix 12

### Questionnaire for Community Focus Group Discussion

1. What do you know about health?
2. What do you know about mental health?
3. Could you tell your experiences with mental patients?
4. Could you explain about any mental patient that you have seen?
5. Could you tell some causes of mental illness ?
6. What might be good ways that we have to behave with mental patients?
7. Do you think current practice of behavior shown to mental patient is satisfactory? Why?
8. Could tell the name of near by places where treatment for mental illness is available?
9. What are the improvements to be done for the betterment of mental patients?
10. What role might be necessary from the family towards mental patients?

## Appendix 13

### Patient Interview Form 'A'

Date:

Name:

Age:

Sex:

Address:

Name of PHC /HP:

Name of interviewer:

---

Please answer all the question reading carefully. Your information will be valuable to improve further mental health service. So you are requested to answer all the questions below.

1. How long you have been treating from this PHC / HP?
2. What was the duration of your illness when you visited first time to PHC / HP?
3. How did you know that mental health service is available at PHC / HP?
4. Did you come to PHC / HP alone or with relatives at first visit?
5. How long you have to wait to get consultation in your first visit to PHC / HP?

6. From PHC /HP consultation, how much you were satisfied?
  - a) Very much
  - b) Unsatisfactory
  - c) Somewhat satisfactory
  - d) Very much satisfactory
 Why?
7. How long time takes to reach to PHC / HP from your home?
8. How much healthworkers could understand your problems?
9. Did you get any medicine after check up? Yes No  
 If yes, what was given (Write the names of medicine consulting patient follow up card).
10. Have you taken medicines regularly? Yes No  
 If not why?
11. Did healthworker ever explain about the method of taking medicine?
12. Did healthworker tell you about possible side effects of the prescribed medicines and it's remedy?
13. Have you been told te possible duration of treatment?
14. Did you inform about the need of regular follow up once treatment started?
15. Did healthworkers provide any information to your family about your treatment?
16. Do you think there was improvement in your condition (in percentage)?
17. What are the areas you felt improvement if you compare before starting treatment and now? Improvement can be explained in terms of symptoms, occupation, family life and social life.
18. What can be done to improve current mental health services of PHC / HP?

### Form B:

**Please ask these questions to relatives of mental patients if they are available.**

1. Did your patient ever refuse to come to PHC / HP? Yes No  
 If yes why?
2. In your experience, what is the status of mental health service provided this PHC /HP?
3. Have you seen any change in your patient after initiation of this treatment?  
 If yes, please specify the areas of improvement such as personal care, work efficiency, family relation and social life.
4. What can be the role family in the treatment of mental patient?
5. Did you receive any advice / suggestion from healthworkers about the role of family in the treatment of mental patient?  
 Yes No  
 If yes specify.....



## Appendix 14

### Comparative information of community focus group discussion

#### Kaski vs. Palpa community focus group information

Information on	Study group (Kaski)	Control group (Palpa)
Definition of health	<ul style="list-style-type: none"> <li>• Good physical structure or body, good appetite</li> <li>• Being free from sickness, maintained personal hygiene.</li> <li>• Clean condition of health</li> </ul>	<ul style="list-style-type: none"> <li>• Health means increased cleanliness of home, toilet, do not take unhealthy food and water.</li> <li>• Have sleep on time, fresh air in the morning, healthy body.</li> <li>• Capable to work, free from diseases.</li> <li>• Improved hygiene, drink boiled water.</li> <li>• Mind must be clean and free from impure thinking.</li> </ul>
Definition of Mental health	<ul style="list-style-type: none"> <li>• Being free from mental tension, mental torture, be practical with the situation, free from anxiety, be cooperative with others</li> <li>• Could feel relax and comfortable, be able to think with patience.</li> <li>• Being free from worries and anxieties.</li> <li>• Person who can bear mental tension easily is mentally healthy and those who could not are not mentally healthy.</li> </ul>	<ul style="list-style-type: none"> <li>• It is a way to keep mind peace and prevent from being madness.</li> <li>• It is ability to remember properly from the brain.</li> <li>• It is a free of tension as it can occur disorder of mind.</li> <li>• Free from worry and unnecessary thinking.</li> <li>• Way of satisfying one self.</li> </ul>
Symptoms of mental illness what they know	<ul style="list-style-type: none"> <li>• Showing abnormal behavior such as becoming naked, social withdrawal, running away from home, wandering around the village aimlessly, neglect in personal hygiene, eating, rejected from family and village, suicidal attempt, drinking excessive alcohol etc.</li> <li>• Do not obey social rules, is often restrained at home, they are called 'boulaha' or madness.</li> <li>• Fainting attack, frothing from mouth, which occurred frequently. There is no proper treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• Children could not see, walks in own idea. In fainting attack people put shoes in mouth. There is increased frequency of fit.</li> <li>• Self-talking, talking excessively, forgets often as such people keeps things in other places and could not remember easily.</li> <li>• Mentally ill people some commits suicide also.</li> </ul>
Causes of mental illness	<ul style="list-style-type: none"> <li>• Due to not fulfill desires, things.</li> <li>• Lack of ability tolerate frustration, tension</li> <li>• Increased demand and limitation as well.</li> <li>• Have more tension</li> <li>• Problems in love affairs</li> <li>• Excessive worries and anxieties</li> <li>• Some are due to not to have marriage</li> <li>• Fainting and some are due to too much study</li> <li>• Marital problems (problems in the relationship between the couple).</li> </ul>	<ul style="list-style-type: none"> <li>• Poverty</li> <li>• Burn accident</li> <li>• Brain injury</li> <li>• Due to hearing bad events or information such as loss of property, death or failure in exam etc.</li> <li>• Taking excessive anxiety</li> <li>• Lack of proper support and peaceful environment in the family.</li> <li>• Not able to study or not able to control frustration.</li> </ul>
Behaviors shown towards mental illness	<ul style="list-style-type: none"> <li>• Help in fulfilling basic needs such as food, water, maintain personal hygiene.</li> <li>• Try to understand their anxieties and help accordingly.</li> <li>• Help according to the type of mental illness and source</li> </ul>	<ul style="list-style-type: none"> <li>• Provide medicine regularly as advised from health post.</li> <li>• We should behave well with mentally</li> </ul>

	<p>of cause.</p> <ul style="list-style-type: none"> <li>• Help in treating such patient.</li> <li>• Find out the cause if it is related to family factors and treat from health workers.</li> <li>• We should not provoke to such patient</li> <li>• Our behavior to them is not appropriate. We should help them in treatment and provide love.</li> <li>• It is not good to restrain mentally ill patient.</li> <li>• The behavior that we are doing is satisfactory as we are helping in treatment, supporting them emotionally and not behaving equally.</li> <li>• Behavior shown towards such patient is not good rather there were more ignorance, lack of care and we are not accepting them.</li> <li>• Government has to help in creating awareness that how to care mental patients and their family.</li> </ul>	<p>ill.</p> <ul style="list-style-type: none"> <li>• Provide love and affection, behave according to mood of patient.</li> <li>• Some of them suffered due to excessive love, if so, they should be scolded as well. If aggressive we should put restrain for his and other safety.</li> <li>• We should take care such providing food, cloth, provide medicine on time, and behave without discrimination.</li> <li>• We should be careful if they hold weapon.</li> </ul>
<b>Treatment center</b>	<ul style="list-style-type: none"> <li>• Basic treatment is available at health post. We have to take to Pokhara if patient are not getting better.</li> <li>• Treatment is available at Pokhara or Kathmandu.</li> <li>• It is available at health post</li> <li>• We have to take them to traditional healers for treatment.</li> <li>• Some cases were taken to Valor, India for further treatment if they were not getting better from health post treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment is not available here. We have to take to Tansen Hospital or Butawal (3 participants).</li> <li>• We used to take Gorakhpur earlier.</li> <li>• We have to ask with other people where the mental health service is available.</li> <li>• India such as Ranchi or Gorakhpur.</li> <li>• Will visit health post and we will take wherever they advised.</li> </ul>
<b>Improvement to be done in treatment of mental illness</b>	<ul style="list-style-type: none"> <li>• Lack of trained manpower in health post as health post people often see such cases as a trial. It would be better to have specialist in health post.</li> </ul>	<ul style="list-style-type: none"> <li>• What government can afford. This service has needed more in remote than here. But would be better if we can arrange mental health service from our health post.</li> <li>• Training is needed for the health staff in health post. It can make service available quickly here in our own village and majority people will be benefited from this service.</li> </ul>
<b>Role of family in treatment</b>	<ul style="list-style-type: none"> <li>• Family need help to have understanding of such mental health problems. Family has to take responsibility in providing medicine, take for regular follow up.</li> <li>• Family has to help in finding out the cause of mental illness and has to take to psychiatrist some time for better diagnosis and treatment.</li> <li>• Good family relationship always helping quick recovery.</li> </ul>	<ul style="list-style-type: none"> <li>• Family has to behave properly while dealing with such case. They must be helpful to mentally ill patient in providing food, maintaining personal hygiene, supporting emotionally.</li> <li>• Family member has to take for regular treatment.</li> </ul>

### Syangja vs. Kapilbastu community focus group

Information on	Study group (Syangja)	Control group (Kapilbastu)
<b>Definition of health</b>	<ul style="list-style-type: none"> <li>• Being free from disease is healthy person</li> <li>• Being free from disease and disability</li> <li>• Person who is fit and sound from all aspect</li> <li>• Physically and mentally healthy</li> </ul>	<ul style="list-style-type: none"> <li>• Free from illness</li> <li>• Be healthy and physically fitness</li> </ul>
<b>Definition of Mental health</b>	<ul style="list-style-type: none"> <li>• Appropriate functioning by the brain and mentally healthy.</li> <li>• Free from mental tension</li> <li>• Balance in mental functioning</li> </ul>	<ul style="list-style-type: none"> <li>• Mental fitness.</li> <li>• Free from tension and sorrow</li> <li>• Not to think too much or shade tears</li> <li>• Free from problems</li> </ul>



	<ul style="list-style-type: none"> <li>Free from anxiety and worries.</li> <li>Being healthy from all aspect.</li> </ul>	<ul style="list-style-type: none"> <li>Have no mental weakness.</li> <li>Have regular food and free from mental tension.</li> </ul>
<b>Symptoms of mental illness what they know</b>	<ul style="list-style-type: none"> <li>Easily felt being hurt even from minor things.</li> <li>Fainting attack lasts 1-2 hrs. to 1-2 days or 1-2 months.</li> <li>Talking excessively, withdrawal.</li> <li>Wandering aimlessly and doing as they like without considering social restrictions.</li> <li>Losing insight, orientation</li> <li>Abnormal behavior such as being naked, talking irrelevantly.</li> </ul>	<ul style="list-style-type: none"> <li>They often found to be anxious excessively.</li> <li>'Boulaha' or madness</li> <li>Scolding and abusive to others</li> <li>Do not talk with others</li> </ul>
<b>Causes of mental illness</b>	<ul style="list-style-type: none"> <li>Heredity</li> <li>Excessive worries</li> <li>Negative major life events, having poor mechanism and poor feeling</li> <li>Disease in brain</li> <li>Some time due to chronic physical illness</li> <li>Failure in SLC</li> <li>Failure in love affairs</li> </ul>	<ul style="list-style-type: none"> <li>Tension and too much thinking as too much thinking can lead to insane</li> <li>Lack of opportunity</li> <li>Lack of proper sanitation</li> <li>Anxiety</li> <li>Lack of appropriate diet</li> <li>Shading tears can cause damage to brain</li> <li>Being faint or unconsciousness</li> </ul>
<b>Behaviors shown towards mental illness</b>	<ul style="list-style-type: none"> <li>We have to help to find out the cause and it's solution and treats the cause.</li> <li>We have to take for treatment. We have to behave properly with patient as like others.</li> <li>We should not mind even if they get angry, show love and affection. Family relationship must good and has to talk well with patient.</li> <li>Treat if the condition is severe in hospital.</li> <li>Some time while they become aggressive, we have to put them in restrain though it is not a solution.</li> <li>Do not let them feel inferiority. We should not reject such patient, search the cause and take to hospital for treatment.</li> <li>More than 50% people in family were not behaving properly with mental patient though they knew it is not good. Treatment is possible only when family member were ready to help. If there is good behavior in family, society will also behave properly. Society has to help to understand the situation. So family has major role in rehabilitation of such patient.</li> </ul>	<ul style="list-style-type: none"> <li>Give medicine</li> <li>Provide proper diet</li> <li>Do not criticize, tease, scold or abuse to mentally ill</li> </ul>
<b>Treatment available</b>	<ul style="list-style-type: none"> <li>Treatment is available here in health center. If not cured we have to take to Kathmandu. Treatment is also available at Palpa, Pokhara.</li> <li>Health post often could not treat major cases for we need to go other center.</li> </ul>	<ul style="list-style-type: none"> <li>We have to take to India (Lucknow) as treatment is not available here.</li> <li>We don't know</li> </ul>
<b>Improvement to be done in</b>	<ul style="list-style-type: none"> <li>There must be a separate section in health post to treat mental patient.</li> </ul>	<ul style="list-style-type: none"> <li>Arrange for adequate food and drinks.</li> <li>We were behaving as we know such</li> </ul>

treatment of mental illness	<ul style="list-style-type: none"> <li>• Increase level of awareness in mental health, as patients were getting better from health post treatment.</li> <li>• Awareness program in school area is helpful to aware school student and teacher in metal health.</li> <li>• Develop metal health facility regularly in health post in future as well.</li> </ul>	as taking them to traditional healers.
Role of family in treatment	<ul style="list-style-type: none"> <li>• To make better is the responsibility o family. Family member should behave properly.</li> <li>• We have to take such patient to hospital to find the cause, should provide medicine regularly, take care in personal hygiene and should take for regular follow up at health post.</li> <li>• Treat for any physical illness such as fever..</li> <li>• Take such patient to health post for regular treatments, better care in food, personal hygiene, provide love and affection.</li> </ul>	<ul style="list-style-type: none"> <li>• We did not know very much that how to behave with 'pagal'</li> <li>• We were trying to treat locally with traditional healers. We have to look after in food, drink, sleep and should support to make them feel calm and relaxed.</li> </ul>

### Nawalparasi community focus group information

Information on	Study group (Dumkouli)	Control group (Chore Mara)
Definition of health	<ul style="list-style-type: none"> <li>• Health is being free from disease and dirt.</li> <li>• Make body clean (personal hygiene), take good food, use clean things, put surrounding clean.</li> <li>• Health will be good if we could get proper air and water.</li> <li>• Health is keeping clean all body including surroundings hygiene. We should not take rotten or dirty foods.</li> <li>• Health means one should be healthy mentally and socially.</li> <li>• It is capable to work, sick person could not work.</li> <li>• Could work well, feel satisfied and be quiet.</li> <li>• Healthy body and free from diseases.</li> </ul>	<ul style="list-style-type: none"> <li>• It is good health and life for own self and family member as well. health is necessary for good life.</li> <li>• Healthy means being right from every aspects.</li> <li>• Maintain hygiene and environment</li> <li>• Free from disease.</li> <li>• No pain and distress</li> <li>• Clean and tidy.</li> <li>• Face and brain cease to function.</li> </ul>
Definition of Mental health	<ul style="list-style-type: none"> <li>• If brain is well, it works properly.</li> <li>• It is free from anxieties.</li> <li>• Healthy brain.</li> <li>• Have good relationship in family and others.</li> <li>• Mentally ill person could not behave satisfactorily.</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy from mental imbalance. Whatever activities done by brain are mental health.</li> <li>• Brain should work properly (healthy).</li> <li>• Ability to control all the activities within one-self.</li> <li>• Many diseases can attack, but we must be free from them. Have goods home and neighborhood environment.</li> <li>• Don't know (2 participants).</li> <li>• Brain cease to function properly in mental illness.</li> <li>• There must be optimal supply of food and nutrients to brain such vitamin. It is free from anxiety sources.</li> </ul>
Symptoms of mental illness what they know	<ul style="list-style-type: none"> <li>• Such patients talk too much, getting angry, fights and aggressive with other.</li> <li>• Could not aware about own body, surroundings.</li> </ul>	<ul style="list-style-type: none"> <li>• Shouting while walking, talks irrelevantly.</li> <li>• Fainting attack while looking bright</li> </ul>



	<ul style="list-style-type: none"> <li>• They have sick brain.</li> <li>• Such patient walks aimlessly, become aggressive with others.</li> <li>• There was weeping spell, influenced with bad spirit.</li> <li>• Talks unnecessarily, walks in his/ her thinking, not aware about what own-self is doing.</li> <li>• Such patient shows disorganized behavior, talks irrelevantly.</li> </ul>	<p>red color cloth. Would become worse if we irritate and release quickly if we do not pay much attention.</p> <ul style="list-style-type: none"> <li>• Could not move limbs, unable to walk.</li> <li>• Wander aimlessly (as seen in insane 'pagal).</li> <li>• Forgetfulness, not sociable.</li> <li>• Headache and thinking too much.</li> <li>• In between behave odd and eccentric way, gets easily angry, not talking, eat food careless, talks too much, not maintained personal hygiene.</li> </ul>
Causes of mental illness	<ul style="list-style-type: none"> <li>• Due to excessive worries and thinking.</li> <li>• Can occur due to internal disease.</li> <li>• Due too much source of stress and anxieties.</li> <li>• Due to lack of love and affection.</li> <li>• Conflict in family can also cause mental illness.</li> </ul>	<ul style="list-style-type: none"> <li>• Self dissatisfaction</li> <li>• Thinking too much unnecessarily.</li> <li>• Heredity</li> <li>• Lack of better home environment</li> <li>• People having hot blood.</li> </ul>
Behaviors shown towards mental illness	<ul style="list-style-type: none"> <li>• We have to be patience towards mentally ill patient. They will not behave badly if we could sit quietly.</li> <li>• We have to talk well, provide food, clothes.</li> <li>• Help them to have proper follow up in health post.</li> <li>• We have to give love and talk well with the patient. We should not beat such patient.</li> </ul>	<ul style="list-style-type: none"> <li>• We were behaving as we know.</li> <li>• Mostly we afraid because we don't know how to behave with such patient.</li> </ul>
Treatment available	<ul style="list-style-type: none"> <li>• Simple treatment is available here. Kathmandu and Pokhara are better place because drugs are available there.</li> <li>• Health post service is good, however we have to buy medicine. Treatment is available at Dumkoul PHC, Naranyanghat.</li> <li>• Some time we were taking such patient to India such as Ranchi.</li> <li>• Take to traditional healers.</li> </ul>	<ul style="list-style-type: none"> <li>• Naranyanghat, Kathmandu and India (Gorakhpur, Ranchi)</li> </ul>
Improvement to be done in treatment of mental illness	<ul style="list-style-type: none"> <li>• Would be better to have visit by mental health expert at least once in a month.</li> <li>• Would be better if we can arrange mental drugs and doctor regularly.</li> <li>• Health post management system should be improved.</li> <li>• Drug should be available freely and mental doctor has to visit twice a month.</li> </ul>	<ul style="list-style-type: none"> <li>• Survey of blood is needed to find out the risky group of health and also run awareness raising activities in mental health. Mental health specialist has to visit at least once a month to supervise the trained health staff.</li> <li>• Government has to provide mental health service free of cost.</li> </ul>
Role of family in treatment	<ul style="list-style-type: none"> <li>• Family has grate role in recovery however, doctor is the main person to treat.</li> <li>• Provide medicine and take patient for treatment.</li> <li>• Provide love and affection and other care as well.</li> </ul>	<ul style="list-style-type: none"> <li>• Family member has to take responsibility to take to health post for treatment.</li> <li>• Family has role in assuring about the intake of regular drugs by such patient. They often need reassurance, talks well and support from family members.</li> <li>• Family has to provide help to reduce pain and other distresses.</li> </ul>

## Rupendehi community focus group information

Information on	Study group (Lankapur VDC, Lumbini)	Control group (Motipur VDC)
Definition of health	<ul style="list-style-type: none"> <li>• Health is being free from disease (7 participants).</li> <li>• Being healthy means free from harm in health.</li> </ul>	<ul style="list-style-type: none"> <li>• Being free from diseases, which is great luck, have all the immunization since pregnancy.</li> <li>• Maintain personal hygiene, have good diet.</li> <li>• It is mental and physical health, have good diet.</li> <li>• Have more mental awareness.</li> <li>• Capable to work physically and mentally.</li> </ul>
Definition of Mental health	<ul style="list-style-type: none"> <li>• Mental health is adequate functioning of sensation or no disorder in brain.</li> <li>• Could tell what is right and wrong.</li> <li>• Don't know.</li> <li>• In mental health brain is in good condition.</li> <li>• Free from disease in brain.</li> <li>• Could think well, have no load in the brain.</li> <li>• Have appropriate brain.</li> <li>• To be happy, sadness can cause illness.</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Mentally unhealthy is not able to think and speak properly as like sick. If a person free from it, he/she is mentally healthy.</li> <li>• Mentally unhealthy is just opposite of health. They can think in any matter.</li> <li>• It is how to save from being illness. Mentally healthy person can analyze what is right and wrong.</li> <li>• Protect from unhealthy factors.</li> <li>• Mentally healthy person can think and response appropriately to the situation, able to work.</li> <li>• Is not bother, success in work.</li> <li>• They are bale to differentiate from wrong and right and follow accordingly.</li> </ul>
Symptoms of mental illness what they know	<ul style="list-style-type: none"> <li>• Such patient walks unnecessarily, talk too much, irrelevant talk.</li> <li>• Could not speak, listen</li> <li>• Frothing and fell down</li> <li>• Wandering in street or walking without wearing shoes or walking holding useless things or stick in hand.</li> </ul>	<ul style="list-style-type: none"> <li>• Wandering around being aimlessly (like insane or 'Pagal').</li> <li>• There is loss of mental balance</li> <li>• Children were not bale to study.</li> <li>• Don't know (2 participants).</li> <li>• Loss of smile while talking.</li> <li>• Mental retardation Loss of awareness about own-self (insight and judgment).</li> <li>• Could not work properly.</li> </ul>
Causes of mental illness	<ul style="list-style-type: none"> <li>• Due to increase heat in brain or thinking excessively.</li> <li>• Disorder in brain</li> <li>• Due to lack of food and awareness</li> <li>• Due to encountering of sudden difficult situation</li> <li>• Too much thinking, worries and being fail in exam.</li> <li>• Due to lack of adequate pressure inside the brain.</li> <li>• Due to worries and unexpected major life events.</li> </ul>	<ul style="list-style-type: none"> <li>• Due to quarrel or conflict in to home.</li> <li>• Mental tension</li> <li>• Excessive alcohol leads to madness.</li> </ul>
Behaviors shown towards mental illness	<ul style="list-style-type: none"> <li>• We have to take such patient to hospital.</li> <li>• To provide medicine and wait for god help.</li> <li>• To give medicine which will make better.</li> <li>• To give medicine</li> <li>• Help to take hospital.</li> <li>• Help in providing food, wearing cloth and toilet, take to hospital.</li> <li>• Talk and activate patient and take to hospital.</li> </ul>	<ul style="list-style-type: none"> <li>• We were showing behaviors as we know such as avoiding such patient because they can harm to others as well.</li> </ul>



Treatment available	<ul style="list-style-type: none"> <li>Lankapur hospital (Lumbini PHC) by 6 participants.</li> </ul>	<ul style="list-style-type: none"> <li>Don't know.</li> <li>In Butawal, mental health specialist visits from Kathmandu.</li> <li>India such Ranchi</li> <li>Kathmandu-in Kathmandu medical College hospital.</li> <li>Treatment is at Dhulikhel.</li> <li>Traditional healers such as <i>Lama</i> and <i>Jhankris</i>.</li> </ul>
Improvement to be done in treatment of mental illness	<ul style="list-style-type: none"> <li>Regular availability of mental health service.</li> <li>Well trained doctors   health post.</li> </ul>	<ul style="list-style-type: none"> <li>Appropriate behavior</li> <li>Find out the way to solve problem.</li> <li>Provide love, no anxieties or worries.</li> </ul>
Role of family in treatment	<ul style="list-style-type: none"> <li>Take to hospital or doctor.</li> <li>Ask with doctor how family can help.</li> <li>Take patient wherever doctors told or go to doctor.</li> </ul>	<ul style="list-style-type: none"> <li>Provide appropriate behavior to such patient.</li> <li>Be Sympathetic to become closure.</li> <li>Provide love and affection.</li> <li>Do not put patient alone.</li> <li>Family has to treat, as neighbor could not do that job.</li> <li>Help to be cooperative at family.</li> <li>No rejection and hate in home but provide love.</li> </ul>

### Tanahu community focus group information

Information on	Study group (Damauli community)	Control group (Tharpu Community)
Definition of health	<ul style="list-style-type: none"> <li>Health means have good, clean and sound health.</li> <li>A healthy person is capable to work physically and mentally.</li> <li>Health person is capable to fulfill all the needs.</li> <li>It is ability to maintain hygiene such as taking good food, fruits, morning exercise, free from mental tension and satisfaction.</li> <li>Health is to be clean and put clean environment.</li> </ul>	<ul style="list-style-type: none"> <li>Good health</li> <li>It is free of any problems, being fit from all aspects, free from disease.</li> <li>Every part of our body is healthy.</li> <li>Healthy body, take fruits, vegetables and meat in food. Have better hygiene.</li> <li>Hood hygiene, washing hand, feet. Clean urine and stool properly.</li> <li>Take more cereals, fruits, <i>lito</i>, milk and milk products.</li> </ul>
Definition of Mental health	<ul style="list-style-type: none"> <li>Mental health means to have good muscles and physics, free from anxieties.</li> <li>To be mentally healthy we should not think seriously. There is relation between thinking and feeling.</li> <li>I don't know (two participants)</li> <li>Mental health is being capable to solve when there is any problems.</li> <li>To be free from worry and anxiety.</li> <li>To be free from worry, anxiety and take initiation in daily activities as like others.</li> </ul>	<ul style="list-style-type: none"> <li>Cleanliness of own body.</li> <li>Self protect of own body. Do not drink alcohol.</li> <li>Eat properly, wear properly and have good weight.</li> <li>Free from anxiety and worry as it can cause disease.</li> <li>No disease inside mind. No drinking of alcohol.</li> </ul>

<b>Symptoms of mental illness what they know</b>	<ul style="list-style-type: none"> <li>We were not behaving well with mentally ill. Treatment would be better.</li> <li>I have feeling to help mentally ill people.</li> <li>Some mentally ill patient talks too much and could not remember it.</li> <li>It can occur for every body. Feeling of dissatisfaction can occur for every body. We have to help not only own self but also for others.</li> <li>Ill people could be recognized from their face.</li> <li>We can help providing money for treatment.</li> <li>Feel pity, would be better if every family member love them.</li> <li>Such patient did whatever they like which is fearful.</li> <li>Have mentally ill patient in urban area.</li> <li>Some patients were talking self and were withdrawal from society.</li> <li>Other people might spoil to such patients.</li> <li>Mentally ill patient smokes cannabis and demands cigarette.</li> <li>One Christian patient had kept without treatment, had kept without treatment and recovered later. They often walked naked, behave abnormally.</li> <li>Madness, epilepsy are mental illness.</li> <li>One child 15-16 yrs is not working properly, eats cannabis. Some people cry, shout, shaking body if they eat goat meat. They showed stammering talks.</li> <li>Eats whatever they get.</li> <li>Brooding too much, self talk.</li> <li>It is 'tin kakhure rog'.</li> </ul>	<ul style="list-style-type: none"> <li>After fever, could not speak and is mentally retarded.</li> <li>Mad people walk holding the dirt and useless things.</li> <li>Do not want to take medicine, always follows own idea and do not follow what other says.</li> <li>Epilepsy cases are seen in village.</li> <li>Some mentally ill patients were seen walking around.</li> <li>Could not die also, visits every where.</li> <li>Did not speak in epilepsy.</li> <li>Faint while walking, more than 10-12 times a day.</li> </ul>
<b>Causes of mental illness</b>	<ul style="list-style-type: none"> <li>Heredity as it is there with parent.</li> <li>Lack of love, major life events.</li> <li>Due to witchcraft.</li> <li>Occurs from within.</li> <li>When family members become ill, bad idea can come due to witchcraft.</li> <li>Due to not able to think properly thinking negatively and not fulfill the desire.</li> <li>Failure in the desire work.</li> <li>Due to barriers to reach to the objectives or if other's take over in the work, too much worries or thinking.</li> <li>Not proper food (rotten foods).</li> </ul>	<ul style="list-style-type: none"> <li>When there is too much anxiety.</li> <li>When drinks too much alcohol.</li> <li>Due to worry, anxiety and economic status.</li> <li>Due to the condition of house, use of drugs or substance.</li> <li>When there is no good environment at home, or have more number of children.</li> <li>Lack of good support in the family.</li> </ul>
<b>Behaviors shown towards mental illness</b>	<ul style="list-style-type: none"> <li>Provide more love and affection, fulfill the desires, and take hospital for treatment.</li> <li>Provide love and affection as much as possible, take to hospital.</li> <li>Fulfill the desire, treat properly, otherwise, patient may die. It is better to treat on time if illness is severe.</li> <li>Provide love- affection, emotional support, find out the cause, take to mental hospital or to better hospital.</li> <li>It is not good, we should not behave badly, should give opportunity to work or talk properly.</li> <li>Earlier, we used to take them to traditional healers. Now a day we are taking to Damauli Hospital.</li> <li>Some people behave well, some not. We should not beat restrain but good behavior help in recover. It is satisfactory to look after in home than restrain.</li> <li>Would be better if treated.</li> </ul>	<ul style="list-style-type: none"> <li>We have been advising such family to take mentally ill patient to hospital. Do not allow taking unsuitable things.</li> <li>Provide reassurance.</li> <li>One should not take worry, anxiety.</li> <li>Encourage them to take medicine by themselves.</li> <li>Find out and ask them to go to health center.</li> <li>Reassure family member that it will be better after taking treatment.</li> <li>Behave properly discuss speak politely, talk in family.</li> </ul>



<b>Treatment available</b>	<ul style="list-style-type: none"> <li>• Not in Damauli but available at Kathmandu.</li> <li>• We ask with villagers may be at kanti hospital but don't know. It is not available at Pokhara but may be at Bharatpur.</li> <li>• Available at Kathmandu</li> <li>• It is available here, can be diagnosed properly. If not get better we advised such patient to go to Kathmandu, Pokhara or India.</li> <li>• Kathmandu, Pokhara, Bharatpur</li> <li>• I came to know that mental health service is available here in Damauli Hospital from hoarding board in the hospital it self. I didn't get information from other part</li> <li>• Don't know.</li> </ul>	<ul style="list-style-type: none"> <li>• Take health post or hospital</li> <li>• It is not available at Damauli.</li> <li>• India –Ranchi (tree participants).</li> <li>• Not available in Nepal.</li> <li>• Don't Know.</li> </ul>
<b>Improvement to be done in treatment of mental illness</b>	<ul style="list-style-type: none"> <li>• Improvements in drug supply, free treatment. Because mental patient often could not treat by themselves due lack of money.</li> <li>• We need to have more efficient doctors to treat in hospital.</li> <li>• We need easy facility to treat mentally ill.</li> </ul>	<ul style="list-style-type: none"> <li>• Do not get angry</li> <li>• Ask them to take medicine. Discuss situation. Try to put happy and quiet.</li> <li>• Treat in better place.</li> <li>• Better if it is available here.</li> <li>• Mental illness will be better as quickly as we start treatment.</li> </ul>
<b>Role of family in treatment</b>	<ul style="list-style-type: none"> <li>• We have to provide care and affection. Do not discriminate, behave properly.</li> <li>• We have to help to take hospital, show love.</li> <li>• Ask patient what happen. Do not disturb if they were not making noise.</li> <li>• Do not in feeling of such patient, would be better if we can take to hospital for treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• Family should be cooperative.</li> <li>• Treat and take to hospital for treatment on time.</li> <li>• Be supportive with mental illness. Encourage and provide medicine. Such patient has to have good relationship.</li> <li>• Talk well and reassure them that it will be recovered.</li> </ul>

## Appendix 15

### Comparative information among trained and untrained health workers in the issue of integration, supervision and reporting

Information regarding the integration of mental health in health post	
Study group health workers	Control group health workers
<ul style="list-style-type: none"> <li>• Integration is necessary and could be done as like other health services. Regular support from mental health specialist is needed.</li> <li>• Integration could be done through coordinating with HMG and developing regular work plan.</li> <li>• To integrate mental health services training for all health post staff and supply of free drug are needed</li> <li>• Since mental health problem is a public health problem, to fulfill objectives of government to provide basic health service at grassroots, integration is necessary. Basic and refresher training to all the health staff and regular supervision is necessary.</li> <li>• Mental health service at health post level increases the trust of community people towards health post service because it reduces the economic burden of patient.</li> <li>• Patients could get service on time in their own community.</li> <li>• Health post can provide this service with same facility and manpower, so would be cost effective.</li> <li>• Increased flow of mental patient at health post.</li> <li>• Integration can be done making coordination between public health department and training center or hospital.</li> <li>• Integration is necessary to continue the current mental health service.</li> <li>• Integration could be done giving equal importance to mental health service also from government. However, training to health post staff, supply of drugs, and system of recording and reporting in mental health is necessary.</li> <li>• It can be done through adding the mental health component in to primary health service system.</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health is also health-related program. Trained manpower and availability of drug is necessary to start mental health service. It would be effective if we can establish a separate mental health section in the district health office from where this program can be run to health post and sub-health post. Awareness raising activities in mental health in the community is equally necessary.</li> <li>• To provide easy and cheap service.</li> <li>• To achieve the goal of health service, integration can be done by running mental health clinic once a week.</li> <li>• Many mental patients were visiting to health post. Poor patients could benefit.</li> <li>• Integration can be done through providing training to health workers and start mental health activities in an integrated manner with other activities.</li> <li>• To make available of mental health service throughout the country like other health service.</li> <li>• From the same physical facility and staff of health post, this service can be provided.</li> </ul>



## Supervision information

Study group	Control group
<ul style="list-style-type: none"> <li>• To know effectiveness of treatment</li> <li>• To refresh the knowledge and skill of trained man power</li> <li>• To know health post difficulties and helping to solve them.</li> <li>• To increase awareness and provide counseling</li> <li>• For the satisfaction of the patient</li> <li>• Helps to treat new patient</li> <li>• Public trust</li> <li>• Reporting of mental health activities</li> <li>• Review difficulty in case management</li> <li>• Encourage health staff</li> <li>• District level supervisor to run supervision regularly.</li> <li>• Evaluate the effectiveness of the program</li> <li>• Rehabilitate patient in the community</li> </ul>	<ul style="list-style-type: none"> <li>• To evaluate the effectiveness of service.</li> <li>• To review the progress of the patient</li> <li>• Enhances the quality of service</li> <li>• To know prevalence of mental health service</li> <li>• To follow the defaulter cases</li> <li>• Supervision twice a year from higher authority</li> <li>• Maintain record of the service</li> <li>• Increase treatment compliance from patient</li> <li>• To solve the clinical problems</li> <li>• To bring uniformity in the treatment.</li> </ul>

## Reporting and recording system

Study group	Control group
<ul style="list-style-type: none"> <li>• Helps to know details of patient such as diagnosis and treatment</li> <li>• Helps in supervision and increase flow of patient.</li> <li>• Provides progress information of patient</li> <li>• Helps in reporting</li> <li>• To get service easily and quickly</li> <li>• To know prevalence of patient.</li> <li>• To know information on drug stock</li> <li>• To make easy in follow up of patient</li> <li>• Has to be integrated with the general health recording system of district.</li> <li>• Helps in reporting to higher authority.</li> <li>• Change in current recording system</li> </ul>	<ul style="list-style-type: none"> <li>• Recording can be done making separate register</li> <li>• Recording provides detail information of patient demography, prognosis and drug.</li> <li>• Recording provides information about the health manpower involved in the service</li> <li>• Recording is helpful in future plan</li> <li>• To information to higher authority or others</li> <li>• Separate HMIS form for mental illness is suggested.</li> </ul>

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