Australia-Nepal Mental Health Network
make a difference

Report on Initial Planning Work in Nepal

ROTARY CLUB OF ORANGE DAY BREAK

Rotary Club of Swoyambhu
RI District 3292, Club No.: 63636

Hike Himalaya Adventure Pvt. Ltd.

Partners in Community Development under
Rotary Australia World Community Service

A Team Report:

Australia – Nepal Mental Health Network: November 2014 and April 2015

Version 18/7/2015

We dedicate this report to the people of Nepal who, since the team visited them in November 2014, have experienced the catastrophic impacts of a number of major earthquakes in April and May 2015.

All correspondence:

The Australia-Nepal Mental Health Network

Dr Nicholas Burns
Chair
Robyn Murray
Treasurer
Robyn Jeffrey
Secretary

Patron
Prabhat Kiran Pradhan

Postal Address:
Dr N. Burns
Mental Health Services
Forest Road, Orange NSW 2800
Australia

Project Email:
robyn.murray3@health.nsw.gov.au

nicholas.burns@health.nsw.gov.au

Note: Any errors in fact are solely attributed to Australian team report writers

Contents

"…we were welcomed everywhere in Nepal…." Dr Nick Burns

Foreword

Namaste.

As Chair of the Australia-Nepal Mental Health Network established in Australia in July 2013, I am honoured to write this foreword to the report on our first formal visit to Nepal in November 2014.

The Australia-Nepal Mental Health Network team is composed of senior mental health professionals. As a volunteer group from Australia we are keen to offer what we can to support the endeavours being made in Nepal to improve the lives of people with a mental illness. We are guided in our planning and deliberations by international mental health experts here in Australia and in Nepal. We are auspiced by Rotary Australia World Community Services (RAWCS) for this project. While we cannot offer direct funding we can offer expertise and collegial networks.

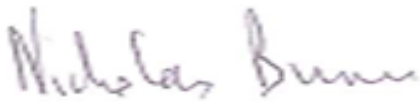
Our aim for the visit of two weeks in November 2014 was to hear directly from Nepali colleagues about how our group may be able to assist them to address some of the challenges they face in delivering effective mental health services.

We were welcomed everywhere in Nepal. People from "all walks of life" in the city and the rural areas were immensely supportive of our aims and engaged with us about the issues they are facing and what could be offered to address some of their challenges.

We believe our trip was successful in that we explored connections and possibilities for support from Australian mental health professionals. We met and worked with a range of people in Nepal and have come away with some knowledge of the issues for Nepal and ideas for joint work. We made many new friends and learnt a lot ourselves.

This report summarises our learnings from our brief engagement over those two weeks in November 2014. It proposes ideas for future collaborations over the next five years. The report has been discussed with our Nepali colleagues and has gained endorsement by them. Also included in this final report is a summary of a planning visit made by a member of the team, Robyn Murray in April 2015.

We look further to our further work in Nepal.



Dr Nicholas Burns FRANZCP MBBS
Chair, Australia-Nepal Mental Health Network
18th July 2015

Our journey

Monday 17th & Tuesday 18th November
We flew into Kathmandu from Sydney and booked into the much loved and venerable Kathmandu Guest House in the Thamel area of the city. We visited the ancient sites of Pashupatinath and Bodnath and enjoyed great food and great company.

Wednesday 19th November
The team drove out to the edge of the city to visit Aasha Deep or "Light of Hope" a residential mental health centre run by Maryknoll Nepal. We had lunch with the residents and heard from Sister Roslyn the incredible stories of bringing the first women with mental illness out of the prisons in 1993.

Thursday 20th November
Another service visit was to KOSHISH – the staff headquarters and the transit home for women from the streets who have a mental illness. Again we were treated to lunch as well as a musical recital. How lucky we are to see such wonderful examples of local services.

Friday 21st November
Last night we were guests at a reception at the Australian Embassy along with our Nepali colleagues. Today the first Australian Nepal Mental Health Exchange was opened by the Australian Ambassador H.E. Glenn White to look at ways to support our colleagues in Nepal.

Saturday 22nd November
Well…. we thought some of our Australian roads were rough! Today we travelled out to a remote region – Dhading – to start our training work in the villages of Maidi. Welcomed with garlands and music, we settled into our tents under the huge Himalayan skies.

Sunday 23rd & Monday 24th November
The team including our Nepali team members worked with the manager at the Health Post and the senior teachers. We did MHFA training, MH awareness in the school and held a clinic. WHAT A TEAM!! On **Tuesday** we returned to Kathmandu for meetings (see report).

1. EXECUTIVE SUMMARY

Background

The Australia-Nepal Mental Health Network was founded in 2013 by a volunteer group of clinicians with extensive experience in the provision of mental health services in Australia.

Members of the group now come from a broad range of professional backgrounds both in Nepal and in Australia, including medical, nursing, social work, occupational therapy, and pharmacology. The Network has links with the Movement for Global Mental Health and Rotary Australia World Community Service (RAWCS).

We are concerned by the plight of those suffering from mental illness in Nepal, and are keen to use our own experience and resources to help in whatever way possible. We are also aware that there are many people already doing this necessary and rewarding work in Nepal, and we know these people work with great skill, selflessness and dedication.

Our aim is to help, but we do not wish to duplicate services which already exist, or teach local clinicians what they already know. We come, therefore, with humility, enthusiasm and inquiring minds. We do not want to intrude or make matters worse. We also expect to learn from Nepal and its people about how we can do our work better in Australia.

Fact-finding visit November 2014

Our planning for this visit took over twelve months. Eight Australians travelled to Nepal led by Dr Nick Burns, a forensic psychiatrist and Robyn Murray, a senior mental health manager and social worker. There were three senior psychiatric nurses, Julie Corkin (postnatal speciality), Robyn Jeffrey (rehabilitation speciality) and Nanette Fogarty (psychogeriatric speciality); a forensic mental health occupational therapist Yvette Black, and a psychiatric diversional therapist and social worker in-training, Evelyne Foucaut. A film-maker and environmental scientist, Peter West, accompanied the team.

The team was partnered by Prabhat Kiran Pradhan, a senior social worker and founder of a rehabilitation service based in Kathmandu, Sujan Shrestha, Maidi Health Post, Bidhya Bhandari, a social worker from Trishuli, and our in-country support Prakash Aryal, Director, Hike Himalayan Adventures and his wonderful staff.

Mary Brell, Rotarian from Orange and her teaching and health training project in the remote villages of the Dhading region of Nepal is the progenitor of the work we are beginning. We extend many thanks to people from Rotary and other individuals who helped support the village work and the forum through donations. The partner Rotary clubs are Rotary Club of Orange Daybreak and Rotary Club of Swoyambhu, Kathmandu.

The Australian Ambassador to Nepal H.E. Glenn White and his staff are to be acknowledged for their generous advisory support with the visit.

What we did

In Nepal, the group

- Hosted a forum opened by the Australian Ambassador, H.E. Glenn White, of senior clinicians, academics and non-government organisation (NGO) staff
- Visited two key health services run by NGOs in the Kathmandu valley which are providing residential and community based mental health services
- Dialogued with practitioners and senior international and national government and NGO managers and advocates
- Attended a reception held at the Australian Embassy for Australians doing volunteer work in Nepal and Nepali colleagues, and
- Travelled up to a remote village (Maidi) in the Dhading region for three days to hold a consultation clinic with the local primary health manager, facilitate a reorientation course in Mental Health First Aid for primary health workers, and conduct the first mental health awareness-raising session in that region for school children.

Our learnings

We recognise that we cannot scope fully the issues and challenges in the field of mental health for Nepal. Nor can we cover in detail all the work that is being conducted by local services. Our Nepali friends and colleagues are the experts.

> *"Our team (and colleagues across Australia) are very excited about continued work – under your guidance – in Nepal. We loved meeting you all and were highly impressed with the work that is occurring in your country, albeit with limited resources." …Team email to Nepali colleagues, Dec. 2014*

From our own perspective, what we learnt was that while there are examples of contemporary practice in the field of mental health care in Nepal resources per capita are extremely low.

Rural populations have major problems with access to and affordability of quality treatment. Mental health problems are still a major stigma. Key social determinants of psychological morbidity in Nepal relate to the political instability of the last decade. These include trauma and displacement as a result of conflict and family break-up due to migration for work. There are particular problems for women with high rates of domestic violence precipitating mental health problems. Hazardous drug and alcohol use is also high.

There is a very clear desire by the people we met to improve services for people with a mental illness.

There is recognition that building the capacity at the local level in the primary health services and increasing training opportunities nationally will allow Nepal to adapt best practice to their own context.

Our proposals for future joint work

We propose a limited but developmental program over a five year period with continual reviews and evaluations to guide effective outcomes. We will work with our colleagues in Nepal at a network and a national level. We will also focus on one or two local village areas in partnership with local people. What we can offer will be further discussed and shaped over the next two years. We will work together about what is viable and possible within what time-frames. The summary below is detailed on pages 36-39.

> *"Together we can do more"*
> *…Email to team from Forum participant and their staff, Dec. 2014*

Our strategy 2015 – 2020
Our vision is to
Add value to the work already being conducted for people with a mental illness, their families and their communities in Nepal.
Work with, learn from and be guided by our colleagues in Nepal so that we can help them build capacity to improve culturally sensitive and evidence-based services.
In collaboration with services, work at both national and local levels.
Our focus areas will be
Initiative 1: Improve training and supervision for people working in Mental Health in Nepal.
Initiative 2: Facilitate access to mental health treatment for severely economically disadvantaged people of Nepal
Initiative 3: Enhance mechanisms for severely mentally ill patients in regional and remote areas to receive specialist review and treatment, either locally or in Kathmandu
Initiative 4: Raise awareness about mental health problems and mental health care across Nepal. Improve mental health literacy in Nepal.
Initiative 5: Enhance collaboration and coordination of mental health services, government and non-government, across Nepal.
How we will know if we succeed?
We will evaluate each activity as well as the entire project for the five year period.
We will report back annually to our colleagues and listen to their feedback.
We will review and renew our activities as required.
What capabilities will we need?
Through our network of colleagues in Australia and Nepal we will source relevant and skilled mental health clinicians and practitioners to undertake the volunteer work required.
The support for the strategy and the volunteers will be undertaken through the Australia-Nepal Mental Health Network Committee and through partnerships with community organisations such as Rotary, both in Australia and in Nepal.

Dialogue and Exchange

Partners in Recovery Forum

"…together we can do more…" Nepali NGO

2. DIALOGUE AND EXCHANGE

2.1 The Nepali Australian Mental Health Exchange – Partners in Recovery Forum

The forum was held on the morning of Friday 21st November 2014 at the Hotel Shanker, Lazimpat, Kathmandu. It was organised by the Australia-Nepal Mental Health Network, with in-country venue organisation by Prakash Aryal and team from Hike Himalaya Adventures, and support from Prabhat Kiran Pradhan as well as Shristee Lamichhane, from United Mission for Nepal, the secretariat for the National Mental Health Network (NMHN) in Nepal.

There were 36 participants in total with 28 representatives from different organizations and individuals working in mental health sector in Nepal plus 8 members from the Australian team. The morning consisted of invited presentations and then discussion time (a program can be seen at Appendix Two). The Chief Guest was H.E. Mr. Glenn White, Australian Ambassador to Nepal. Our Rotary partner was represented by Professor Dr Sharada Singh, President, Swoyambhu R.C. The Master of Ceremony was Dr Nicholas Burns with facilitators Robyn Murray and Prabhat Kiran Pradhan.

This summary of the forum includes key data, issues and ideas. Further detail on comparative data between the Australian and Nepali mental health systems can be found in a separate report prepared by Evelyne Foucaut with advice from Nepali colleagues.

Objectives of the forum

For the Australian team these were to:

1. Establish networking with organizations working in the area of mental health
2. Learn more about the current state of mental health care in Nepal
3. Present information on the mental health trends in Australia
4. Identify gaps in the services in Nepal
5. Exchange and explore ideas about working together in the future to further improve the mental health care of people in Nepal

Invited presenters

H.E. Mr. Glenn White	Welcome (on behalf of the Australian Government)
Dr Surendra Sherchan	Welcome from Nepal (on behalf of the Nepalese Government)
Dr Nicholas Burns	The Nepal Mental Health Project: what can it offer?
Mr Prabhat Kiran Pradhan	Mental Health in Nepal: current situation
Mr Ram Lal Shrestha	Key Mental Health Issues facing Nepal (for NGO workforce)
Ms Shristee Lamichhane	Key Mental Health Issues facing Nepal (for NMHN)
Mr Matrika Devkota	Key Mental Health Issues facing Nepal (for consumers)
Professor Dr Sharada Singh	Thank-you to participants (Rotary, Nepal)

Introductory presentations

The event was held in the Durbar Hall of the Hotel Shanker which was built as a Rana palace over 150 years ago. This first Australian Nepali mental health exchange was inaugurated by **H.E. Mr. Glenn White**, Australian Ambassador to Nepal and **Professor Dr Sharada Singh** with the lighting of the oil faded lamp (*Panas*) as a tradition of Nepal.

H.E. Mr. Glenn White (pictured at right) delivered participants a short welcome speech acknowledging the work of the many committed and passionate people in Nepal who are improving services for people with a mental illness. Mr White wished the forum every success.

Dr Nicholas Burns presented the objectives of the workshop along with ways the team could assist services in Nepal in the future.

Dr Burns also made a special presentation from the Project Team to **Prabhat Kiran Pradhan** (at right) for his many years of work for his country in the area of mental health and noted that the team had invited Pradhan to be one of the patrons for the project.

Main presentations – facts and figures, mental health services and issues

Presentations from Nepali colleagues are summarised below with additional information added where necessary, from W.H.O. and OECD data sources.

Key Data

Total Population
29 million (2013 approx.)
Geography
Mountain, Hill and Terai
Rural and Remote
85.8% people live in rural areas
GDP - per capita (PPP)
$1,500 U.S. (2013 est.)
Ethnicity
125 ethnic groups
Five development regions
Eastern, Central, Western, Mid-Western and Far-Western; 14 Zones, and 75 districts

Nepal is a multi-ethnic country, with a great diversity of cultures, castes, languages, religions and belief systems. With such diversity in the over 29 million population, 70 different cultural and ethnic groups and over 100 languages, many people live according to their own way of religious practice, lifestyle, language and culture. There are wide discrepancies between different caste and ethnic groups in terms of their relative wealth and access to

education. These factors inevitably impact on the health and mental health circumstances of people in Nepal. Nepali family structures are very strong, and families tend to support their sick family members.

A large percentage of the population live in very poor conditions, mainly around the mid mountainous and Himalayan region where there are very few reliable means of transport and access to education and health facilities. Due to this difficult terrain, infrastructure tends to be very under-developed. Nepal is one of the resource poorest countries in the world. In the United Nations Development Programme Human Development Index (UNDP HDI) Nepal ranks 136 out of 175 countries.

Nepal has 8 of the world's highest mountains notably Mt Everest at 8,848 metres.

Agriculture is the main source of revenue for the economy. Even in the Kathmandu valley, a large percentage of the population rely on farming as income and occupation. Other jobs include general manufactures, goods trading, government officials, hospitality and tourism.

Governance

After 10 years of socio-political conflict, a Federal Democratic Republic of Nepal was established in 2006 as with a Prime Minister as head of the major ruling political party. However, there is still significant uncertainty and instability. A national constitution is still to be accepted and endorsed. The country is still in transition following the Maoist insurgency of the last decade. However, at the socio economic level, in recent years Nepal has made some progress in economic growth, poverty, life expectancy and literacy.

Health services

Each of Nepal's 75 districts is headed by a permanent chief district officer responsible for maintaining law and order and coordinating the work of field agencies of the various government ministries. As is the case in many countries with emerging economies, the health system in Nepal is based on a primary health care system (see box at right).

Nepal: a primary health system

- 11 Zonal Hospitals across 14 zones
- 75 District Health Offices
- 3129 Sub Health Posts for a total of 3995 Village Development Committees
- 698 Health Posts
- 188 Primary Health Centres

Medical hospitals and medical staff in Nepal are very limited compared to resource rich countries on a per capita basis (see example at right). Government funding for health services in general is limited, and consequently services are significantly supplemented by the NGO sector. Many international and national NGOs provide health services in Nepal. However coordination of these services is poor.

*Comparative data (OECD 2009)**
Psychiatric beds per 100,000
Nepal: 0.08 Australia 40
Psychiatrists per 100,000
Nepal: 0.12 Australia: 15
Psychiatric nurses per 100,000
Nepal: 0.08 Australia: 15.6
Psychologists per 100,000
Nepal: 0.08 Australia: 97
Social workers per 100,000
Nepal: 0.08 Australia: 86
*Australia is below, for instance Norway in some data fields but is a good comparator as it has a recent focus on primary care vs tertiary care.

Many Nepali clinicians, including psychiatrists work and live overseas. Out of 50 Nepali psychiatrists worldwide there are

only 20 working in Nepal, including one child psychiatrist. Some medical specialists living away from Nepal return annually to do field work.

Mental health services infrastructure

Mental health services are particularly under-resourced. Mental health services receive just 0.14% of the total annual government health budget, and only a small number of NGOs are involved in the provision of mental health care (less than 1%).

Nanette Fogarty and Paul Hansen

Some local NGOs are funded by large international funding bodies (INGOs) to provide mental health services locally. The INGOs maintain varying degrees of oversight into the functioning of these services. Despite the severe restrictions in funding, there have been some major successes and reforms over the last 3 decades. For example, in the 1990s the practice of incarcerating severely mental ill people was abolished. There exist currently some key examples of good contemporary models of community focussed care in Nepal. However, services are patchy and lack national coordination.

Tertiary services, where available, are mostly centred in Kathmandu and the major cities. There is one public mental health hospital of 45 beds located in Kathmandu. Rural populations have major problems with access and affordability. They are dependent on government-funded primary health clinics which generally have no access to medical staff and are very under-resourced. Free medications are very limited, and there are no psychotropic medications available on the government free list. Access to private health care and medication is unaffordable and unavailable for most people.

> *"No health without mental health"* .....NMHN statement (W.HO. 2009)

Recent advocacy and the consequent recognition of the rights of people with a mental illness have led to the development of a draft mental health act and the establishment of a mental health unit in the government. There is continuing work to further develop the MH Act from all sectors with support from the W.H.O. to ensure it balances both clinical and disability / psychosocial support paradigms.

Matrika Devkota, Dr Bushan Guragain, Yvette Black

A national network of mental health services (National MH Network - NMHN – see Appendix Three) has been re-established (March 2012). It has the overarching aim of improving coordination of services within the NGO sector, and also improving collaboration with the government sector. The Network is committed

to the implementation of a national mental health policy, mainstreaming of services, reducing stigma, collaborative partnering with consumers and promoting awareness of mental illness.

David Johnston and Kunday Kaphle

Mental health data

Data suggests that the rates of mental health problems are high. Perhaps as much as 25% of people presenting at primary health clinics have mental or behavioural disorders often masked as multiple physical complaints. Hazardous drug and alcohol use is also high.

Studies have demonstrated the impact of political instability and internal conflict as major social determinants of psychological morbidity in Nepal. In the last few decades internal displacement and international migration for work, and domestic violence are factors precipitating mental health problems.

Presenters also noted that more women (65-68%) are presenting with anxiety symptoms and depression. Violence against women is common, especially in regional areas and areas where alcohol use is greatest. Studies have also indicated a high prevalence of psychosocial problems among school children in a study of 30 districts.

Traditional beliefs

In Nepali culture mental illness is still, for the most part misunderstood and feared. When a person is determined by their family or community to be insane (or mentally ill) that person may be deprived of his/her social, legal and civil rights. People with a mental health disorder may be rejected by their family altogether. If they are violent or non-productive they may be locked up or chained up. In rare circumstances they may be incarcerated in prison, although this practice is now rare.

Extreme poverty combined with a limited understanding about mental illness and belief in traditional treatments, may impede referral to appropriate health services.

Discussion

Two questions were discussed: Question 1 – What activities/actions are suitable for the team? Question 2 - What are your expectations of outcomes? The discussions are summarised below under broad headings:

Activities and actions suitable for collaboration

Workforce development

- A conference/ conferences
- Assisting with development of a national training manual for NGOs – mental health and social counselling training
- Assistance to further develop self-help groups

"Training needs to be embedded and ongoing"….participants

- Training – targeted and specific to cover gaps: training the trainers, mentoring, peer supervision, clinical supervision, supervision, peer working
- Supporting the further development of social workers, occupational therapists, MH nurses, D&A counsellors and peer workers
- Supporting the development of holistic, recovery oriented practice

Dr Chhatra Amatya

Awareness-raising

- Region by region and across the country: connect through Rotary clubs and or other clubs/ mainstream community organisations throughout Nepal to establish a MH literacy program
- Involve consumers and families in this project
- Highlight the impact of violence against women that leads to mental health problems
- Campaigns for the community on the prevention and response to suicidality
- Help support programs to raise awareness of hazards of D&A misuse.

Policy and service planning

- Consider supplementation and support for research
- Develop National Exchanges – dialogue around developing services, effective management practices, "new thinking", "the roads we are each walking"

Service development and delivery

- Assistance from Australian experience on setting up telepsychiatry to remote areas
- Advice and support on how to set up and maintain effective suicide hotlines
- Supporting capacity building in remote areas and primary health posts
- Supporting the setting up of skill development programs for people with a mental illness
- Expertise to assist with VETE programs (Vocational Education Training and Employment)
- Expand the Australian Government volunteer program to assist services

"Helping individuals to be independent leads to society accepting them" … forum participant

Expectations of outcomes

- Development of curricula with local trainers
- National manuals that provide standards and consistent content
- Guidance and assistance that is culturally contextual
- Outcomes are incremental, achievable, measurable, documented (show evidence) and evaluated
- Take steps that are slow and incremental
- Achieve something every year
- Local people are listened to, to ensure activities are effective and meaningful

- Training activity is provided
- Technical support is available e.g. for telepsychiatry and clinical expertise
- The level of commitment (length and type) is clear and agreed
- Cross learning, liaison and MH networks established within Nepal and between both cultures and countries
- Increased capacity of existing MH professionals
- Cost effective delivery of care e.g. use of telepsychiatry
- Skill development for people with a mental illness
- Reduction of stigma and societal acceptance
- Guidance and assistance is available throughout the year – for instance make capacity building available through use of skype

Dr Nick Burns and Dr Dhruba Man Shrestha

Next steps

Dr Nick Burns noted that the outcomes of the forum would be collated into a draft report along with the results of the team's other visits to services and its trip to the village/s of Maidi in Dhading. This would then be circulated to all colleagues for any feedback before being endorsed as a report. The report would be a "living" document subject to change with new information. It will, nevertheless chart some further steps in collaborative work and interchange between Australia and Nepal in the field of mental health.

On behalf of the Rotary Club of Swoyambhu, a vote of thanks was offered by **Professor Dr Sharada Singh**. Dr Singh emphasised to all the great ability of people when working together to be able to make a difference to the lives of others.

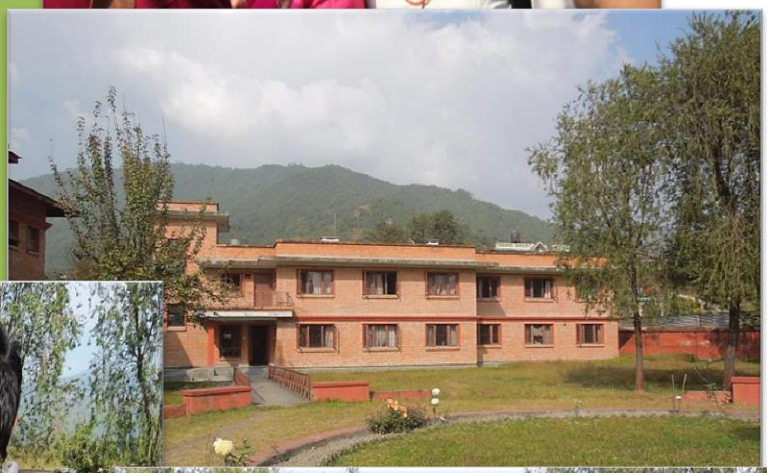
Thanks to Prabhat Kiran Pradhan and Nanette Fogarty for their transcriptions of the Forum and to Evelyne Foucaut for her background work.

Dialogue and Exchange

Service Visits

Aasha Deep

"….we were warmly greeted by both staff and residents…" Yvette Black.



2.2 Service visits

As there was limited time the group could only visit two key NGOs working in the field of mental health care. We recognise that many other vital services exist, in both the non-government and government sectors. It is hoped that we will be able to visit other key services in future visits.

The sites visited this time were the Aasha Deep Mental Health Rehabilitation Centre and KOSHISH, both services run by NGOs.

Aasha Deep, "Light of Hope"

The team visited this service on Wednesday 19th November.

Aasha Deep, or "Light of Hope" is a residential Rehabilitation Centre built 14 years ago by Maryknoll Nepal, a charitable organization founded by the Maryknoll Fathers and Brothers of New York state.

Maryknoll Nepal is a local NGO first established in 1993 to provide treatment and rehabilitation for women with severe mental illnesses who were being held in Kathmandu's Central Jail, despite having committed no crime. At the time, this was a commonplace practice for dealing with 'uncontrollable' mental illnesses.

Following the resounding success of this early program, Maryknoll Nepal expanded its mission to provide a broader range of psychiatric services to the poor and socially disadvantaged of Nepal.

It has worked collaboratively in its mission with other international major funders including the Japanese government and Misoreor, a German charitable organization. They have established a range of services including outpatient services, day care centres, and its flagship service, the Aasha Deep Residential Care Centre.

Aasha Deep lies about 20km north of Kathmandu at the edge of the Kathmandu valley. It was originally built in open fields, but the local environment has become more urbanized since that time. Despite this it is still a pretty site and invokes a sense of asylum and sanctuary. It is surrounded by several acres of gently sloping fields for the cultivation of crops and raising farm animals.

The physical environment comprises of 3 main buildings, a residential block which can house up to 40 residents in dormitories (20 men and 20 women), a communal block housing the kitchen and dining facilities, and a further building containing offices, some rooms for residential staff and some single rooms for private fee paying patients.

One of the bedrooms

On the day of our visit, we were warmly greeted by both staff and residents. The Centre is currently caring for close to 40 patients, most of whom suffer

from severe and enduring mental illnesses such as schizophrenia or schizoaffective disorder. It is clear that many residents remain very symptomatic from their illnesses and have considerable functional deficits. Most residents require a high degree of support for daily functioning.

Despite this, residents are strongly encouraged to assist in the daily functioning of the organization, and participate in the cleaning, cooking, and farm duties. The residential buildings were very clean and neatly presented, and the patients showed great pride in their living spaces.
Whilst the aim of the service is to restore these patients to fully independent living, it has proven a great challenge to progress the care of these people into the community.

This is due in part to the challenge of reuniting them with families who may not accept their mental illness. It is also a challenge to provide these people with the skills and means to generate an independent income in the community. Some of the residents have been living here for many years, including some of the original cohort of women who were rescued from the prisons in 1993.

The service currently faces many serious challenges.

First, it is in serious financial jeopardy, as its sources of substantial recurrent funding were lost in 2012. It now relies on local fund raising, which is sporadic and unreliable. It receives almost no government assistance. Increasingly, the Centre has had to accept private fee paying patients, which reduces its capacity to care for the most socially disadvantaged, for whom the service was developed.

Second, its clinical programs have deteriorated due to serious staff attrition and recruitment difficulties, partly a flow-on effect of the funding crisis. Clinical care is provided mostly by staff members who, despite their dedication, have very limited opportunities for training and professional skills development. The service has very limited access to psychiatrically trained nurses, and almost no access to occupational therapy or clinical psychology.

In view of these challenges, the service faces the possibility of being taken over by the Nepalese government.

Despite these recent issues, it is clear that Aasha Deep has been a leader in the provision of mental health care in Nepal.

We were delighted to meet the wonderful staff, many of whom have been involved since the organization's inception. These included Mr Prabhat Kiran Pradhan, senior social worker and Maryknoll board member, Mr Kumar Dahal, social worker and current clinical leader, and Dr Shresthra, senior psychiatrist and Maryknoll board member.

Dr Burns and team with Mr Kumar Dahal, manager, Aasha Deep

We shared a delicious locally produced meal with our hosts, and gained many insights into the wonderful work they do and the challenges they face.

Above all we felt very privileged to spend time with the wonderful residents who have created a home here, and who impressed us with their strength, resilience and optimism for the future. They have helped to create a community which will hopefully continue to prosper.

A wonderful lunch at Aasha Deep

Robyn Murray talking with Sister Roslyn who was instrumental in bringing women with mental illness out of prisons in Nepal in 1993

Dialogue and Exchange

Service Visits

KOSHISH

…there was a strong sense of camaraderie and a unified vision…..

KOSHISH

On Thursday 20th November we had the pleasure of visiting the offices of KOSHISH in Lalitpur. KOSHISH is a Non-government organization, which was founded in 2008 by Matrika Devkota. Its overarching aim is to give a voice to those who have experienced mental illness first hand, and to utilize their insights and experience to identify gaps in existing services and to advocate for improvements in services.

KOSHISH has four main arms to its service, a) The Advocacy and awareness program, b) the Peer support program, c) the Women's rehabilitation and Reintegration Program, and d) the district level Community Based Mental health Program.

We were highly impressed by the scope and breadth of services provided by this small organization which runs on a very restricted budget. We also felt that the service model reflected contemporary trends in practice and thinking from around the world.

We started our visit at the administrative offices of KOSHISH in Lalitpur. We had the opportunity to meet Matrika and his dedicated team (names, and specific job titles). The team members are from diverse professional backgrounds with varying levels of professional training. The team includes a lawyer whose primary focus is to act through strategic political channels for legislative change and enhanced government service development. KOSHISH recognizes the need to work with government, as well as with other NGOS services.

The team was highly enthusiastic and clearly imbued with the passion and zeal of KOSHISH's founder. There was a strong sense of camaraderie and a unified vision. It was evident that the organization aims to work with service users to optimize recovery and to sponsor their right to social inclusion through access to employment, stable housing, social relationships, and all the other benefits of society.

We had the opportunity to visit the Women's transit home, also in Lalitpur, which is the accommodation base for the Women's Reintegration and Rehabilitation Program. The home provides temporary accommodation to homeless women who have been rescued (?an emotive term) from across Nepal by the KOSHISH team. Many of these women are suffering from schizophrenia, and the vast majority experience some kind of mental illness. Many have been rejected by their families and have been victims of domestic violence. They experience extreme poverty, isolation and social dislocation. The KOSHISH team responds to calls from agencies (often local police) all over Nepal, and is prepared to travel even to remote areas to rescue women.

Our team was highly impressed and moved by what we saw at the transit home. The home is clean and spacious, and is providing accommodation and holistic treatment, including medication, for 20 women and some children. The women are given social roles and practical functions, and participate actively in the running of the home. Whilst providing a sanctuary, it is stressed by KOSHISH that this is temporary only, and that community reintegration is the ultimate goal.

Our team was treated to a delicious lunch prepared by the women, and later to a moving musical recital by 2 of KOSHISH's 'graduates'. We also had the opportunity to shop at their handmade jewellery store!

Dialogue and Exchange

Remote Village Training and Consultations - Dhading

"…each morning we would wake to the gigantic mountain of Manaslu towering above the villages of Maidi…." Robyn Jeffrey

2.3 Remote village clinical consultations and training – Dhading

The team visited the remote villages of Maidi, Saat Dobate, Dhading from 22nd – 25th November 2014.

Dhading lies 85 km to the north west of Kathmandu, a drive that nevertheless took over five hours, often over quite difficult terrain.

"The journey included almost two hours of deadly but adventurous and shaky ride after we left the main road, one should experience this at least once in a life-time"….PK

With local advice we focused for this visit on conducting the following services:

- Mental Health First Aid (MHFA) Refresher Training Course
- Mental Health Awareness Program for the local school students
- Mental Health Check-up Camp

The village work was conducted side-by-side with the local primary health officer, Sujan Shrestha and the key staff from the village and the village schools. The team included Prabhat Kiran Pradhan, a Nepali social worker Bidhya Bhandari from Trishuli, Buddhi Man Shrestha, Teacher, Dhading, Gyanu Bhattarai, Tour and Logistic Manager/Hike Himalayan Adventure (HHA) and Keshav Aryal, Local Logistic Manager, HHA.

The planning for our work was guided by

- *Sujan Shrestha, Head of the Primary Health Post, Maidi*
- *Prabhat Kiran Pradhan*
- *Buddhi Man Shrestha and Krishna, Maidi Schools*
- *Prakash Aryal, HHA*
- *Betty Kitchener, AM, CE, Mental Health First Aid, Melbourne, Australia*

This village visit followed in the footsteps of previous visits conducted by the Rotary Club of Orange Daybreak (RCOD) in Australia which focused on training in teaching and health. These visits were instigated in 2012 by a member of RCOD, Mary Brell.

As part of that project, RCOD funded a first ever rural MHFA course there in 2013. It was conducted by Dr Arun Jha, PK and local Nepali professionals for the primary health workers. Under the auspices of a Rotary Australia World Community Service (RAWCS) program our team is committed to this region for the next three years.

The people of Maidi made our visit very memorable. We were welcomed with warmth and generosity by everyone we met. We arrived at harvest time and the countryside looked beautiful, green and golden fields of rice terracing along the hillsides and neatly maintained stone and timber farm houses. The giant mountain of Manaslu rose to greet us out of the clouds as we climbed higher. The roads were "interesting" and reminded many of us of

outback journeys in Australia after the rains. We understood well the meaning of access issues and remote areas.

We received a beautiful and heart-felt musical welcome from the villagers when we reached at our destination. All the team members were offered garlands and khatas and red tika as well as flowers from the children. We were accompanied by the villagers with traditional music and folk dances up to our tent camp.

The Mental Health First Aid (MHFA) Refresher Training Course

The MHFA reorientation was led by senior clinician, Prabhat Kiran Pradhan ('PK') with the assistance of the team. The participants were the local volunteer health workers as well as local health teachers, family members, social workers, many of whom attended the 8 hour MHFA course 19 months previously (April 9, 2013).

MHFA participants

The objectives of conducting the 4 hour refresher course were to:

- Conduct an evaluation of previous MHFA training
- Explore the benefits of the previous training on the clinical practice of participants
- Refresh the knowledge base and build on previous learning with additional training
- Help participants build on their level of competence and confidence

Initially, participants completed a Standard MHFA course Session 1 / Exercise 1.1a, assessing retention of knowledge from the previous training. The course was then conducted with power point presentation in Nepali. The session was conducted in participatory method rather than lecture format to encourage interaction by the students. The training focused on common psychiatric diagnostic groups (mood disorders, psychoses, anxiety disorders, substance abuse) and basic management planning (ALGEE).

"Greetings from Melbourne: Congratulations. I think MHFA-Nepal is the first to launch a refresher MHFA course." Betty Kitchener AM, CEO, Mental Health First Aid Australia

MHFA ALGEE

- *Assess for risk of suicide or harm*
- *Listen nonjudgmentally*
- *Give reassurance and information*
- *Encourage appropriate professional help*
- *Encourage self-help and other* support strategies

The outcome of the 4 hours refresher course was encouraging. The trainees participated enthusiastically and showed a keen interest in the material.

The analysis of the evaluation questionnaire of the initial MFHA training showed the following trends:

- There were more female participants than male

- Male participants overall showed a greater retention of knowledge, though a female participant scored the highest overall mark
- The overall average score was greater than 50%, suggesting reasonable retention of knowledge
- Of the participants over 80% reported that they had been able to help at least 4 people experiencing mental health problems or emotional distress since the initial training was conducted.

These results combined with the interest and participation of the primary health workers in the reorientation course suggest that the MHFA course, translated into the Nepali cultural context may be a valuable instrument for teaching and training regional and remote health workers.

The Mental Health (MH) Awareness Program to the School Students

The MH awareness raising course was led by PK with the assistance of part of the team.

Evelyne Foucaut and Julie Corkin with Maidi schoolchildren

This was the first time a MH awareness program was conducted in a school in the Dhading district. The target audience of this program was the students of classes 8, 9 and 10 from the local schools. The program was conducted in Amarai High School and students from five other local schools joined in, the group totaling around 60 students.

The content of the course was developed in such a way that students studying in these classes would understand the theme of the course and grasp the information and knowledge about mental health easily at their level.

Humour and graphics were introduced during the presentation to make the session lively. We were encouraged by the high level of interest and the number of questions that came from the students throughout the session. We were encouraged that the students are being taught to adopt an inquiring and critical attitude to the learning process. We were also impressed by the intelligence and enthusiasm of the students. On the top of that, we were happy to see teachers also could be present during the course along with their students.

"Beyond our imagination, the session was very much lively and one could see the joy and enthusiasms and curiosity on the face of students"… PK

"The next day when my students returned to their classes in Maidi they all requested that they have more courses and discussions on mental health." … Buddhi Man Srestha, head teacher Maidi

The Mental Health Camp: Maidi Village, Dhading Region

The joint clinical consultation work was led by Dr Nicholas Burns ('Dr Nick') in collaboration with United Mission to Nepal (UMN), Dhading cluster (Focal person: Sujan Shrestha) and PK, Bidhya and the team. It was conducted at the Saatdobate health post primary health post over one and half days on 23rd and 24th November.

Bidhya, Nick and PK

At the beginning of the clinic all the team members were formally welcomed by the staff members of the health post with the offering of khatas and flowers along with a brief introduction and welcome speech by Sujan.

The main objective of the health camp was to provide consultation and expert opinion for the local health leader, Sujan, about diagnosis and management of common psychiatric disorders. Encouragingly, some basic training has already taken place under the auspices of local NGO, UMN. Sujan has access to basic diagnostic instruments and a small range of free medications for treatment of common disorders. Unfortunately, these medications are older agents more prone to producing unwanted side-effects. Also, there is very limited expertise in non-pharmacological treatments. Despite this, the team was very impressed by the high level of competence shown by the local health workers in the field of mental health.

> *"Hats off to the Hike Himalaya Adventure, who provided packet lunch (Australian Type), water and tea during each day and at the right time before anyone could feel starved, thirsty or sleepy.'… PK*

The camp had been advertised on local radio and people had walked for up to 3 hours to attend, including some people from neighboring regions. The team divided itself into 2 subgroups for the purposes of conducting the consultations, ensuring each group included at least one Nepali health worker. In total 36 people were reviewed over 2 days. In most instances, family members participated. Due to time constraints, each consultation was limited to about 15 minutes. In most instances, the clients were known to Sujan, and the team provided expert option about either diagnosis or management. In some instances, the clients were being reviewed for the first time. Whilst providing advice about medications, the team tried to highlight the benefits of simple non-medication interventions as well.

Data on all clients was collected for simple analysis and to provide baseline information for future follow-up and review. Some basic trends noted were:

- More females participated than males
- Overall the major diagnostic groups found were (in order of frequency) anxiety disorders, psychoses, depressive disorders and mental retardation.

- A broad range of disorders were encountered, similar to those found in western countries
- A significant proportion of the participants did not have a diagnosable mental disorder
- The diagnoses varied based on gender
- Cultural context is essential for providing an understanding of the expression of emotional distress

A summary of thoughts and findings from our work in Dhading are:

- The UMN cluster under the leadership of Mr Sujan Shrestha is doing excellent work in Mental Health. This includes the 5 day training in MH provided by UMN to Sujan and one other health worker and the formulation of a basic history taking and diagnostic template which is now in use in the health post.
- Four students studying in class 9 and 10 (female) presented at the clinic the second day (with their families) for mental health problem counselling. This was a direct result of their participation in the previous day's school orientation program.
- While the access to some free medications is to be commended the range of medication for people with mental health problems is very limited. The older agents which are less effective and carry a greater risk of serious side-effects. This highlights a need for access to a broader range of newer medications. However the newer medications are often prohibitively expensive and most families cannot afford to buy them (e.g. for young people experiencing epilepsy this means that their families have to mortgage their farms to afford the best medication or the person has to accept less optimal medication which will affect their ability to maintain a normal life)
- Depot medications are not currently used, and may be a cost effective alternative to oral medication, especially for psychotic illnesses.
- There is a paucity of access to medical investigations, including screening for basic medical causes of psychiatric disorders. Also, there is limited capacity to monitor for serious side effects of psychiatric medications (e.g. related to lithium use, which us an effective treatment for bipolar disorder).
- The dispensing practices for medication need to be improved. For example there is a need to have in stock at the health post printed envelopes for medication dispensing and a stamp that is filled in with dosage.
- Need to have in stock at the health post printed envelopes for medication dispensing and a stamp that is filled in with dosage
- Local traditional healers and also Christian groups are often involved in the first instance when a person is feeling unwell. It would be helpful to involve these groups in any future training around MH problems
- Women appear to carry the burden of psychological distress. This may be due to a range of broader cultural issues including loneliness, raising children alone, long

working hours and intense physical labour, social isolations, separation from their families, absent husbands and domestic violence. Women's cooperatives may be of benefit in counteracting some of these social factors.

- A better understanding of the social determinants of psychological distress in the Dhading region is critical and must be explored further.

From Sujan Shrestha and local leaders - this is their advice for future activities:

1. Teacher orientation program on mental health
2. School mental health program for six schools
3. Regular psychiatric consultation in Maidi Health Post - once in four months
4. Develop referral mechanism for severe mental ill patients
5. Pastors and traditional healers should be involved in orientation training
6. Special support for those clients who are economically poor
7. Support for conducting telemedicine service

From Sujan and his colleagues in Maidi, January 2015:

"We are very grateful to you and your team for valuable support to conducting mental health camp , refresher training for social workers and health workers and School mental health programme. This programme is very useful for us. I hope, we get this type of support in future as well….

….We started telemedicine programme in Maidi Health Post on every Saturday before 6 months. I hope if we include mental health service, then those patients who are suffering from mental illness can easily get consultation from counsellor and psychiatrists".

Thanks to everyone!!!!!!!!!!!!!!

Thanks to Sujan and Buddhi Man and Prakash and his team and Krishna for hosting us in Dhading….

Thanks to Prabhat Kiran Pradhan for his draft report of the work in Maidi and to the rest of the team for the data (de-identified) that was collected…..

Thanks also to Mary Brell an active member of the Rotary Club of Orange Daybreak (photo at right of Mary with MHFA team in April 2013) … Mary always encouraged us through meetings and skyping and email for the great success of the show - thanks Mary - without your work already in Dhading with the teachers and the health post - the show would not have been as great…

And of course, thanks to all team members for their team work spirit...!!

WHAT A TEAM WE ARE……!!!

2.4 Other dialogues

We met individually with a number of people throughout the visit. These conversations ranged from people who were working in Nepal to local people we met in shops and hotels. A summary of the themes arising from these dialogues follows.

The NGO sector is very extensive in Nepal, and probably the main single source of health care provision in the country. Despite the good work being done by the numerous NGOs, it is important to view the sector with a critical eye. There is often limited coordination between the various providers, and little objective oversight of the standards of care provided. Many of the NGOs are funded by large international donors who take a 'hands off' approach to governance of the sponsored service. There is often little need for locally run NGOs to be accountable to their funding bodies. For these reasons, standards of service provision can tend to vary widely.

The National Mental Health Network is in its infancy and has yet to reach its full potential. Many NGOs working in mental health suffer from the quality of training and supervision of their front-line staff. Learning models tend to be excessively didactic, and this is also reflected in service provision. Teaching and training should ideally adopt a more experiential model, where participants are actively involved in shaping curricula and course content. There needs to be a greater emphasis on quality improvement processes.

Any new service needs to be mindful of these pitfalls in order to make sure it does not replicate old problems. Despite high levels of enthusiasm, there is a risk of either being of no use or in fact worsening the current status quo.

It is difficult to gauge the extent of unmet need in the community, because Nepalis tend not to talk about their feelings, especially unpleasant feelings. Depression and anxiety are not traditionally seen as appropriate subject matter for open discussion. However, there is probably a large amount of suffering and unmet need in the community. There have been some recent suicides of public figures, which have brought the issue of depression into the public arena.

Many sectors of the population, especially minority groups or the marginalized, keep their emotional difficulties concealed. For example there is currently very limited open acceptance of homosexuality in Nepal. Nepali society tends to take an orthodox view of social structure, adopting a hierarchic and patriarchal model, and there is little acceptance of social diversity. The place of women in society is still undergoing change and oppression and violence towards women is an issue.

Even if people are willing to seek help, there is little help available. Most specialist mental health services are located in the major cities, and needs to be funded privately. Awareness

raising campaigns are needed. There is also a need for widely available emergency services. Suggestions were made for 'hot lines' and TV or radio campaigns that could be effective and relatively low in cost.

Forensic mental health was also noted as an issue – where a person has committed a crime while being deemed mentally ill; there is no clear legislation supporting their rights.

People are however expressing a huge thirst for knowledge. They have a very evident wish for civil society to take responsibility for mental health issues, and a desire to improve services using evidence based interventions that are then embedded in a Nepali context.

".... The Nepali society …is changing dramatically which gives us hope for the unleashing of Nepal.." Sujeev Shakya, author and columnist 2013





3. Our Learnings and Proposals for Collaboration

3.1 Summation of our learnings

Culture plays a critical role in the identification, expression, and management of mental illness. Culture defines mental illness and what is considered "normal", expected and adaptive behaviour. It is a dynamic concept and perceptions of mental illness can change over-time. Different cultures have different explanatory models of mental illness compared to western models which influence how people communicate, cope with psychological challenges and their willingness to seek treatment.

As a team going forward we need to be cognisant of our cultural bias and ensure this is filtered through the advice of our colleagues and friends in Nepal.

a) Service structure and governance

- Wonderful work is already being done in the field of mental health care in Nepal by dedicated and committed people. However, access to mental health care is patchily distributed and services are sub-optimally coordinated.
- Most mental health care in Nepal is provided by NGO services or voluntary services.
- The NGOs working in Mental Health Care have loosely amalgamated to form the Mental Health Network
- There are limited government mental health services available. They are concentrated in the 3 cities of the Kathmandu Valley (Lalitpur, Kathmandu, Bhaktapur).
- Government funded services are primarily based around the Mental Hospital and other inpatient services.
- Mental Health Services are allocated a very small part (about 0.14%) of the total government health budget.
- There is some (limited) dialogue between the government and NGO sector.
- The NGO's are engaged in a broad range of initiatives. Some assist in providing direct clinical care. Others are engaged in advocacy, awareness raising, and teaching/training and supervision.
- Some NGO's assist in providing direct clinical care in regional and remote areas, but this is patchy.
- There is currently no mental health legislation, although draft legislation currently exists.

b) Health workforce

- There are few trained psychiatrists (approximately 50) working in Nepal, and the majority of these practice in the 3 cities area.
- There are very few allied health care workers working specifically in mental health care.

- Numbers of mental health specific nurses are low.
- There are very limited options for training in mental health specific disciplines in Nepal. Most training occurs outside of Nepal.
- There is a nascent but strong peer workforce.
- In regional areas, mental health care is provided by the local government appointed health care worker. The level of training in mental health varies widely but is generally very limited. Otherwise, care is provided by volunteer health workers or families.

c) Range of treatment options

- Psychotropic medications are difficult for most people to ascertain, either due to cost or availability.
- No psychotropic medications are available on the government list of free medications.
- Some regional areas are provided with a limited number of psychotropic medications through NGO funding.
- Psychotropic medications are manufactured locally in Nepal and India and are relatively cheap (compared to prices in the Western world). A broad range of medications, including the newer agents, is available for purchase.
- Medications can be purchased without a doctor's prescription on the advice of a pharmacist.
- Non-pharmacological treatments are very limited and usually take the form of supportive psychotherapy. Access to psychological therapies (such as cognitive behavioural therapy) is very limited.

d) Range of psychiatric morbidities

- We observed a broad range of conditions similar to the range of conditions seen in Australia
- Women may experience greater psychiatric morbidity due to social isolation and domestic violence.
- Locally produced alcohol is a serious cause of psychiatric morbidity, especially in regional and remote areas. Alcohol is primarily consumed by men and is a precipitating factor in domestic violence.
- Poverty and isolation are prominent social determinations of poor mental health

3.2 Possible areas of future work

- Capacity building, i.e. training and skills development of clinical and non-clinical staff
    - Training for teachers in Maidi region and for schools, pastoral care and traditional healers.
    - Develop training manuals or assist with curriculums
    - Mentoring and supervision

- Direct funding for staff salaries, rent, and medication. Especially for the very poor, in exceptional circumstances

- Law and policy advice

- Telepsychiatry for both direct clinical consultation and possibly as a means of training and education (or skype or other technology)

- Setting up services such as a suicide hot line, or for front line clinicians to seek advice from experts

- Research

- Direct clinical consultation, could be done by telepsychiatry and occasional visits for eg to Maidi health post, or other health post

- Assist in developing referral pathways to Kathmandu for severely mentally ill patients

- Awareness raising. Maybe through rotary it could be done on a widespread regional basis
    - Radio or TV campaigns

- Assistance in maintenance of national network of services and service coordination

  Associated themes;
  - Decentralization of services, promoting remote and regional services
  - Listening to the locals
  - Collaboration
  - Bidirectional learning
  - Remaining culturally sensitive
  - specific areas of clinical need

3.3 Draft proposed plan of collaboration over 5 years

The skills and mindset for our strategic planning (see conceptual details at Appendix Four) will come from continuously asking ourselves – with you - the following questions about our organization, our programs, and our activities:

- What vision do we want to pursue?
- What will we focus on to make a difference?
- How we will know if we succeed?
- What capabilities will it take us to get there?

Our strategy 2015 – 2020
Our vision is to
Add value to the work already being conducted for people with a mental illness, their families and their communities in Nepal.
Work with, learn from and be guided by our colleagues in Nepal so that we can help them build capacity to improve culturally sensitive and evidence-based services.
In collaboration with services, work at both national and local levels.
Our focus areas will be
Initiative 1: Improve training and supervision for people working in Mental Health in Nepal.
Initiative 2: Facilitate access to mental health treatment for severely economically disadvantaged people of Nepal
Initiative 3: Enhance mechanisms for severely mentally ill patients in regional and remote areas to receive specialist review and treatment, either locally or in Kathmandu
Initiative 4: Raise awareness about mental health problems and mental health care across Nepal. Improve mental health literacy in Nepal.
Initiative 5: Enhance collaboration and coordination of mental health services, government and non-government, across Nepal.
How we will know if we succeed?
We will evaluate each activity as well as the entire project for the five year period.
We will report back annually to our colleagues and listen to their feedback.
We will review and renew our activities as required.
What capabilities will we need?
Through our network of colleagues in Australia and Nepal we will source relevant and skilled mental health clinicians and practitioners to undertake the volunteer work required.
The support for the strategy and the volunteers will be through the Australia-Nepal Mental Health Network Committee and through partnerships with community organisations such as Rotary, both in Australia and in Nepal.

INITIATIVE ONE: Improve training & supervision for people working in Mental Health in Nepal			
Focus Area	Team Lead Partners	Draft Action Plan	Timeline
Build on mental health training provided by UMN for health workers in Maidi district.	- UMN - Maidi health workers	- Establish target group - Liaise with UMN - Liaise with Health workers (Sujan) - Establish gaps in training - Devise training package - Review of training - Consider annual training - Scope options for roll out in other districts	2015 2016 2016 -2018
Provide direct clinical supervision for Sujan and the volunteer health workers in Maidi district	- Maidi health workers	- Liaise with Sujan - Set up visit to Maidi - Set parameters for consultations	2015
Investigate possibilities for provision of supervision by telemedicine in Maidi district	- Orange partners	- Establish equipment needs - Establish human resources needs - Establish local equipment deficits - Establish local set-up and running costs - Source funding, one-off and recurrent - Scope options for roll out in other districts	2015 2016
Conduct training and education forums in Kathmandu.	- MH network - local clinicians - International guests	- Set up working party to conduct feasibility study and needs analysis for one-day education forum in Kathmandu. - Invite advice on content from local stakeholders - Consider options for annual occurrence - Consider attaching to non-clinical forum	2015 2016-2018
Establish an 'Education Fund' for targeted key clinicians and targeted skills acquisition	- ANMH team - PK - Nepali advisors	- Review precedents, such as medical scholarships fund - Set up application review panel - Set parameters for applications - Set annual funding targets - Fund raising - Invite applications	2015 2016
Curriculum advice to universities and other training institutions	- ANMH team	- Liaise with university faculty heads and NGOs	2015-2016
Work with prison officers to raise awareness of mental health and mental illness.	- CVICT	- Further discussions with CVICT - Feasibility study - Roll out of mental health first aid to prison officers and police officers.	2015 2016

INITIATIVE TWO: Facilitate access to mental health treatment for severely economically disadvantaged people of Nepal			
Focus Area	Team Lead Partners	Initial Action Plan	Timeline
Establish 'emergency health care fund' for people of Maidi village, with a focus on small and targeted funding projects. May include, for example, funding of medication, transport costs to health care services in Kathmandu, in-home care, medical equipment.	- Maidi health worker and local village representatives - Nepali and Australian team members.	- Establish committee to manage fund, with cross-national membership. - Establish purpose and scope of the fund. - Establish funding criteria. - Establish fund raising targets and methods. - Invite applications. - External audit	2015 2016
Establish similar fund for other districts across Nepal			2016-2018

INITIATIVE THREE: Enhance mechanisms for severely mentally ill patients in regional and remote areas to receive specialist review and treatment, either locally or in Kathmandu.			
Focus Area	Team Lead Partners	Initial Action Plan	Timeline
Improve referral links between Maidi district health post and government health facilities in Kathmandu.	- The Mental Hospital, Kathmandu: Dr Sherchan clinical director.	- Set up working party to explore options - Consider options in other districts	2015-2016 2016-2018
Provide clinical review and supervision by telemedicine across Nepal			2016-2018

INITIATIVE FOUR: Raise awareness about mental health problems and mental health care across Nepal. Improve mental health literacy in Nepal.			
Focus Area	Team Lead Partners	Draft Action Plan	Timeline
Awareness raising campaigns, exploring options for multiple media including radio, television, print media and social networking media (facebook)	- Local NGOs - National MH strategy	- Explore partnerships with local NGOs who have already worked in this area.	2015-2016
Mental health literacy training for teachers, spiritual leaders and village leaders in Maidi district	- PK		2015
Mental health literacy training for school children of Maidi district		- Explore options for 'train the trainer' education for mental health primary prevention in Maidi. - Seek advice about Australian models of service and cross-cultural applicability.	2015

INITIATIVE 5: Enhancing collaboration and coordination of mental health services, government and non-government, across Nepal			
Focus Area	Team Lead and Partners	Draft Action Plan	Timeline
Host annual conference in Kathmandu for local NGOs and government agencies	- National MH Network	- Working party	2015-
Policy and legislative advice	-	-	

SUPPORTIVE INITIATIVES: Review activities regularly, raise funds as necessary, and recruit and retain a pool of skilled Australian practitioners as volunteers			
Focus Area	Team Lead and Partners	Draft Action Plan	Timeline
Regular internal and external review of activities			
Fund raising			
Recruitment and retention			
Work with support partners such as Rotary			

Appendix One Itinerary November 2014

The Nepal Mental Health Project
Rotary Clubs of Orange Daybreak/ Swoyambhu
Volunteer Project November 2014
Rotary Australia World Community Service
***ITINERARY** Version 9 November 2014*

Nepal Mental Health Care
make a difference

Ex Sydney Sunday 16th November

Day 1 Sydney to Kathmandu ***Monday 17th November 2014***

Yvette, Peter, Robyn J, Robyn M, Nanette, Julie, Evelyne via China Southern Airlines: at 11.20 A.M.; Nick via Singapore Airlines: at 12.15pm; we will all meet up with Prakash Aryl at airport, our local organiser from Hike Himalaya and all together transfer to hotel, Kathmandu Guest House; free afternoon and dinner locally.

Day 2 Kathmandu ***Tuesday 18th November 2014***

Introduction to Kathmandu with Prakash in small bus – Swyambunath, Pashupatinath, lunch and afternoon discussions. Dinner at hotel.

Day 3 Kathmandu ***Wednesday 19th November 2014***

Lead by Prabhat Kiran Pradhan (PK), Founder and National Coordinator, South Asian Forum on Mental Health and Psychiatry, and Maryknoll, travel by small bus to Asha Deep Rehabilitation Centre at Sundarijal; short tour and presentation by PK; meeting with Dr Dhruba Man Shrestha at Nepal Medical College Hospital. Lunch: Tibetan restaurant at Bodnath and small tour. Dinner in the Thamel area near the hotel.

Day 4 Kathmandu ***Thursday 20th November 2014***

Morning: visit to KOSHISH services with Matrika Devkota. Lunch. Afternoon: Visit Garden of Dreams.
Evening: Reception at the Embassy, hosted by the Ambassador for health, university and Rotary officers and partners.

Day 5 Kathmandu ***Friday 21st November 2014***

Morning: Host Mental Health Services Forum at the Hotel Shanker; welcome by Australian Ambassador. Afternoon: further discussions or further site visit to hospital or visit to craft markets or free afternoon; dinner locally.

Day 6 Kathmandu to Maidi, Dhading ***Saturday 22nd November 2014***

Travel to Maidi by four wheel drive; arrive late afternoon; welcome from villagers; stay in tents with all amenities.

Day 7 Maidi, Dhading ***Sunday 23rd November 2014***

Review and discussion about MHFA; education/ consultations with local health workers re complex case issues.

Day 8 Maidi, Dhading ***Monday 24th November 2014***

Counselling and advice sessions, working with local health workers.

Day 9 Dhading to Kathmandu ***Tuesday 25th November 2014***

Travel back to Kathmandu.

Day 10 Kathmandu ***Wednesday 26th November 2014***

Early flight over Everest; more site visits or free day; dinner with Jagannath Lamichanne from Movement for Global Mental Health 6.30pm, meet at KGH.

Day 11 Kathmandu ***Thursday 27th November 2014***

Breakfast with Gael Robertson from NGO, 7.30am KGH. Fly out in morning to Kolkata (Nick) or travel to Chitwan National Park (Robyn J, Nanette, Julie, Evelyne) or trekking (Peter and Yvette); (Robyn M to stay night then to Delhi).

ROTARY CLUB OF ORANGE DAYBREAK

Partners in Community Development

Appendix Two Forum Program

Nepal Mental Health Care
make a difference

The Nepali Australian Mental Health Exchange
Partners in Recovery Forum

Friday 21st November 2014
Hotel Shanker, Lazimpat, Kathmandu

Program		
Time	**Topic**	**Leader**
	Forum Facilitators	**Dr. Nicholas Burns, Australia** **Prabhat Kiran Pradhan, Nepal**
8.45	Registration	**All**
9.00	Welcome on behalf of the Australian Government	**Australian Ambassador** **His Excellency, Glenn White**
9.10	Welcome on behalf of the Nepal Government	**Dr. Surendra Sherchan**
9.20	Mental Health in Nepal: Current Status	**Prabhat Kiran Pradhan**
9.35	The Nepal Mental Health Project: What can it offer?	**Dr. Nicholas Burns**
9.50	Key Mental Health Issues Facing Nepal	**Mr Ramlal Shrestha** on behalf of the private NGO workforce
10.05	Key Mental Health Issues Facing Nepal	**Shristee Lamichhane** on behalf of the members of the National MH Network
10.20	Key Mental Health Issues Facing Nepal	**Matrika Devkota** on behalf of MH Consumers
10.35	Morning Tea	**All**
11.00	Open Discussion: what are the best ways for the Nepal MH Project to lend support?	**All**
12.00	Summary	**Dr. Burns and Mr. Prabhat**
12.45	Thank you	**Prof. Dr. Sharada Singh** **President, Swoyambhu Rotary Club**
13.00	Lunch	**All**
All attendees are welcome to stay on after lunch to continue discussions		

ROTARY CLUB OF ORANGE DAYBREAK

Rotary Club of Swoyambhu
RI District 3292, Club No: 63636

Partners in Community Development

Appendix Three National Mental Health Network

Mission

- People with mental illness and psychosocial disabilities are enjoying their rights and are living a dignified life.

Vision

- Improve mental health and psychosocial services accessibility in the national health system by promoting community based treatment and rehabilitation.

Appendix Four Conceptual Framework for Change

We have used the following construct of strategic planning to develop our proposals. The skills and mindset for our strategic planning will come from continuously asking ourselves – with you - the following questions about our organization, our programs, and our activities:

- What vision do we want to pursue
- How we will make a difference
- How we will succeed, and
- What capabilities it will take to get there.