

Integration of psychosocial counselling in care systems in Nepal

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Abstract

In Nepal, as is the case in many non-Western countries, psychosocial programmes have not been structurally integrated in the care giving spectrum. Integration of psychosocial programmes raises ideological issues and is complicated by practical difficulties. This article describes the current situation of psychosocial counselling in Nepal and what is still lacking, such as supervision systems, promotion of counselling, and effective strategies for community implementation.

Keywords: counselling, psychosocial programmes, training

Introduction

The experience of the Centre for Victims of Torture, Nepal (CVICT)¹ in its rehabilitative work for victims of torture (as well as other groups) indicates that psychosocial² assistance can be a valuable addition to current or traditional forms of care, especially in rehabilitation programmes. As a result, CVICT has developed a culturally sensitive training programme that is long-term, skill-based, using supervised practical placements for a variety of target populations (e.g. children affected by armed conflict, torture survivors, and children in the worst forms of child labour) and a variety of Nepalese care providing centres and organisations³. The structure and content review

of the training programmes are described elsewhere (Jordans et al, 2002; Jordans et al, 2003). The above-mentioned training programme has been used to train more than 100 paraprofessional psychosocial counsellors in Nepal. However, CVICT feels that the training itself is not sufficient to make well-trained and motivated service providers actually reach the targeted populations. Often an array of hurdles separates the successful termination of the training course and the successful implementation of psychosocial interventions, of which three are most notable and interrelated;

1. The training course and the overall project in which the training programme was designed (often a collaborative effort between CVICT and a donor agency) might not always have been sufficiently perceptive towards the situations within the implementing organisations or places; for example, concerning integration of counsellors within organizations, more emphasize needed to be given to existing organizational and care structures.
2. The intervention, as such being new in Nepal, has made implementation difficult, because many people are either sceptical towards such new interventions, or say they are already effecting such interventions (which is often in an untrained fashion, or is an entirely

different form of intervention, often one that focuses on convincing the clients).

3. The targeted organisations (mostly NGO's that run centre-based rehabilitation services) have not always been sufficiently receptive to the trained counsellor suddenly needing to be integrated in the running systems. This seems to be mainly due to the previously mentioned points, the possible difficulties in making organizational changes in existing systems and due to a certain degree of donor-imposed or expected ideas of rehabilitation.

Psychosocial care in Nepal: the current situation

The efforts in the field of mental health and/or psychosocial care are relatively minimal compared to the overall necessity (Robertson, 2001; Ackland, 2002). The following is an overview of the current situation of some specific psychosocial counselling initiatives in Nepal.

Training and education. Many years of relatively short-term training courses, that used to be of a 'Training of Trainers' structure, without a practical component, have in our opinion, proven to be ineffective in incorporating sustainable clinical skills in its recipients. Moreover these courses, often given by expatriate trainers, had little regard for cultural sensitiveness. Recognising this, CVICT developed a long-term training course for psychosocial counsellors, typically of 4 to 5 months in duration. Although a definitive improvement compared to the previous model, CVICT is aware that these training courses in themselves are still insufficient. In order to integrate psychosocial counselling into the Nepalese care setting, CVICT believes that three levels of training courses need to be provided. Firstly the above-mentioned training courses that supply mid-level para-

professional counsellors. Secondly, it is necessary to have a core group of well-educated professional clinicians who will be able to provide clinical supervision in the future, are able to design and advise on psychosocial components and issues within programmes or organizations and are able to play a role in the establishment of the profession as such in the country. To supply such a need, a one-year university affiliated post-graduate diploma course in psychosocial interventions, is presently being conducted by CVICT, in conjunction with School of Applied Human Sciences and in collaboration with Transcultural Psychosocial Organisation, Amsterdam. Thirdly, it is necessary to have a group of less intensely trained people who are able to raise public awareness and identify individuals possibly in need of counselling, both in community and centre based settings, or deal with them as first-line service provision.

Rehabilitation services. Another component of the psychosocial care infrastructure in Nepal, is the actual provision of counselling services in organizations that run rehabilitation programmes. Currently quite a few of the trained counsellors are working in centre based rehabilitation centres, mainly in Kathmandu, seeing clients with relevant issues (for example: *suicidal ideation and post traumatic reactions in a 21-year old woman who has been trafficked for sexual exploitation; feeling of stigma and inferiority in a 14-year old boy due to continued teasing; severe fear reactions of darkness and of being alone in a 11-year old girl due to perceived encounter with a 'ghost'*). Many other organizations in Nepal conduct counselling, but some of these interventions cannot be categorized under the term psychosocial counselling.

Future implementation

For a mature psychosocial care system in Nepal, much still needs to take place, all of

which needs to happen in due time and only in response to actual needs within certain populations. Below, we try to identify some of the main areas of work that need attention for such a full-grown care structure to evolve.

Promotion of counselling. In Nepal few people are familiar with psychosocial counselling. Through several need assessments with people in areas of armed conflict, we have learned that many present psychosocial and mental health complaints as being disturbing and as part of their overall problems, though do not necessarily frame their help-seeking question in terms of psychosocial counselling (partly due to their unfamiliarity of such). Therefore, there is a need to educate people (including care giving organisations, government and the general population) in order for mental health and psychosocial problems to be identified. Children are particularly difficult to identify as having psychosocial problems as they will seldom present themselves for treatment. It is therefore important that those around the child, including rehabilitation centre staff and the child's primary agents of care (such as the children's families, health post assistants, child clubs, teachers) can identify children that are in need of psychosocial care. The fact is then that such people are aware of mental health issues and that normalizing⁴ such issues (to oppose the often attached stigmas) is the starting point.

In order to raise awareness of mental health issues and psychosocial counselling it is necessary: (a) to hold interaction sessions (meetings that combine psycho-education and need-assessment) with relevant centres, organizations, community institutions or people, and with families; (b) to distribute awareness materials (leaflets, posters, drawings etc.); (c) to hold interaction programmes with the local traditional healers

(e.g. *dhamis* or *jhankris*⁵), or other existing care providers, to identify ways of possible collaboration and mutual referral, thereby acknowledging and stressing the role of the traditional healers in the described project and at the same time raising awareness among the same traditional healers about general mental health issues.

As mentioned, merely training good quality counsellors is obviously not enough. It is important to promote employment opportunities in order to place counsellors in an environment where they can deliver services to those in need. They need to be integrated into existing and/or adapted systems in an effective way. Organizations are usually reluctant to change existing care models to incorporate a new intervention. The possible reasons for such reluctance might include the subsequent changes in existing internal hierarchies, the new skills might not be sufficiently prioritized to make the necessary organizational changes, lack of understanding of the importance of psychosocial counselling and resistance to those previously providing services to being replaced by trained paraprofessionals. The first step in creating employment opportunities then is to have the organizations' management on board when trying to make integration happen. In order to achieve that, organizations aiming to integrate psychosocial counselling need to understand the concept, reason and content of psychosocial interventions and the roles of its service providers. For that reason a seminar for this group has been held to install correct understanding of the intervention as such and with the hope of creating employment for those to be trained as counsellors (Tol, 2003; Jordans et al, 2003). Finally, promotion should focus on working towards the creation of national policies regarding psychosocial care. At present

there are not even national policies for the more general field of mental health. National policies should aim to standardise mental health and psychosocial care. This would give legitimacy to psychosocial programmes and encourage government involvement in this field of work in Nepal.

Issues for training courses. Future training programmes for psychosocial counselling, in addition to the effective skill-based approach to training counselling as outlined above, need to be aware of a few critical issues and subsequent programmatic adaptations. We acknowledge some of the critiques (Bracken, Giller & Summerfield, 1995; Summerfield, 2001; International Save the Children Alliance, 1996) that have been raised about the risks of implementing talking-based interventions that might be alien within the existing care giving structures. In our experience we think such service is complementing and relevant, provided it is emphasized that counselling in future programmes should be embedded in a broader healing environment, which includes emphasizing social connections, spiritual/religious activity, recreational activities and encouraging environment, etc.. Such a service should not be trauma/PTSD focused, in the sense that the counsellor does not take the trauma model as the explanatory model, does not automatically explore the traumatic events and the client's deepest feelings towards these, but rather that the counsellor follows the client's perspective, pace and presentation of complaints and explanations of these in order to assist the client. If, in that process, trauma or trauma treatment becomes a relevant issue the counsellor should be able to deal with that accordingly, however still not emphasizing unnecessary forms of exposure. Moreover, interventions like counselling should be culturally adapted and

appropriate (such adaptation has been described elsewhere; Tol & Jordans, submitted). Such interventions should only take place when basic needs are met and a stable and safe environment is present, emphasizing rapport building and trust building as necessary prerequisites for further sessions. These interventions should work with/from the existing coping strategies and resources of the client and community, which also entail collaboration with the primary care agents and existing service provision systems. Such systems should be recognized and strengthened and not be (automatically) replaced by individual counselling interventions. Finally such interventions should be a response to actual needs of the target population.

Making psychosocial counselling a regular health care option. Regulating current capacity building initiatives can include the provision of standardised training for psychosocial counsellors. This could result in official certification giving the new profession a much-needed legitimacy. It also provides clients with a way to assess the qualifications of the service-provider, giving them confidence in psychosocial counselling as a 'mainstream' form of health care. Ideally, courses should be affiliated to academic institutions and/or technical agencies. This is currently the case in CVICT's capacity building programmes.

Secondly, making psychosocial care a regular part of health care should also include that all care programmes take the psychosocial component of their interventions or clientele into account. All health care institutions that provide services to populations who are at risk for mental health or psychosocial problems should thus integrate the possibility of direct or indirect provision of psychosocial counselling, besides other constituents of (health-) care.

Related to the above, but ideally a separate initiative, would be to install a *Council of Psychosocial Counsellors of Nepal*. The role of such council would be to: (a) establish standards in relation to the quality of care; (b) develop a code of conduct for psychosocial counsellors; (c) monitor quality and conduct impact assessment studies of the interventions; and (d) develop protocols or professional guidelines.

Making psychosocial care a regular part of healthcare also entails ensuring the availability of clinical supervision for all trained clinicians and service providers. A supervision system that guarantees that trained psychosocial service providers have the opportunity to receive support, feedback and continued learning.

Implementation of counselling in the current care settings

*Community implementation*⁶. The first step towards community implementation needs to be conducting a thorough community assessment of; (a) the mental health and psychosocial problems as they are experienced; (b) the needs of these children as well as the needs of the larger community to deal with such problems; (c) the local perceptions of distress; and (d) the existing resources and methods present in the community to cope with such problems. This first step includes gaining knowledge of the local service provision agencies within the community.

In implementing psychosocial counselling, the counsellor has to ensure that the relevant primary agents of care are aware of the identified problems and are helping them to react to these, especially as primary care agents might not always be sufficiently equipped to detect or handle distress (Pfefferbaum, 1997). Parents and teachers play a vital role in the healing process of affected children by providing support,

trust, safety and structure. This entails working closely with the families of affected children, where possible and necessary. Research shows that ongoing maternal pre-occupation with the traumatic event(s) and altered family functioning are more predictive of symptom development in children after disaster than is the original exposure or loss (Pfefferbaum, 1997).

Any psychosocial intervention should aim at reconnecting the child with the community; for example engaging him/her in children's clubs (or other group activities) and other existing forms of coping and care. Moreover, it should aim to create a sense of normality; in his/her schooling, recreational activities and cultural/spiritual events, as one of the precepts of psychosocial care. If additional care is found to be necessary, it should initially and primarily be provided by existing care systems (both formal and informal), in which respect traditional healers can play an important role.

Additionally, community implementation should entail working with the community to limit additional negative psychosocial impact by avoiding re-victimization and stigmatisation. The social agents can actively play a positive role in this process. To avoid re-victimising a child, caregivers should not start delving in the child's traumatic history. They should ensure that the child is not confronted with stress invoking stimuli. They should guarantee that confidentiality is maintained (e.g. that the child's story is not used for a purpose that the child does not agree with, such as being published). To avoid stigmatisation, awareness about psychosocial issues needs to be raised and the child's problem(s) and daily life need to be normalized (e.g. by providing justification for the behaviour rather than branding it as bad or abnormal). Unnecessary institutionalisation should be avoided.

Other elements of community implementation should be school based interventions, family and group interventions, out-reach programmes and psychosocial first aid. Psychosocial first aid⁷ aims at giving psycho-education about the problems that the child might be facing, without forcing the child to talk. It also encourages initial social support. It ensures that the basic physical needs are met. It includes the capacity to identify and refer severe mental health disorders, and guarantees that the child gets adequate care and attention. It can be conducted by volunteer community psychosocial workers. (Freeman, Flitcroft & Weeple; 2003).

Centre based implementation. As a result of the decision to integrate counselling, organizations should adopt certain strategies to make integration of psychosocial care within their current care package possible. One strategy that is useful is to provide a written job description and/or terms of references for the counsellor. Such job description should state the counsellor's area of work, responsibilities and daily tasks to be undertaken, thereby clarifying the counsellor's role. Another strategy is to develop an organisational plan of how psychosocial counselling fits into the overall care system, possibly with subsequent adaptations to the existing system. Such a plan should clearly delineate who is responsible for which type of case (or parts of a case) and ensure that proper methods of referral and internal collaboration are in place. For example, a doctor is responsible for a case where a client has been physically injured but may also have to refer the client to the counsellor for assessment if the injury was a result of a traumatic incident. The plan can even go into detail about who should make such assessments, should it be the doctor, or should the doctor refer all cases of possible

psychotrauma to the counsellor for assessment. The organisational plan should state the explicit or implicit status of the counsellor. Such clarification of roles and functions is important to reduce possible frictions between different service providers within an organization.

Counselling should not stand by itself, but be part of a holistic care system. As with the community care described above we stress the importance of the client's surroundings (social, cultural) in the care system. In the centre-based setting this means that the counselling intervention should be part of a healing environment, which is an umbrella term indicating that only a combination of interventions, activities, systems and setting can result in actual healing (Frederick, 2002). Practically this encompasses multi-disciplinary teams (e.g. social worker, doctor, teacher, counsellor, traditional healer) working on cases, recreational and cultural activities, case-management system, supportive staff, adequate physical surroundings (e.g. the availability of a pleasant and private room), inclusion of non-verbal ways of expression within the counselling process, such as dance, music or art. Moreover, the above-mentioned awareness issues are similarly important within the centre-based setting to de-stigmatise clients with mental health problems and/or destigmatize the intervention as one that is needed for 'crazy' people. The above may lead to a need for additional financial and/or human resources.

The role of care-providing institutions and organizations. The importance of the involvement of health care institutions and mental health organizations is crucial. The importance of the role of the organizations' management starts with, but goes beyond, the actual decision to integrate counselling within their care system, offering actual employ-

ment, making terms of references or guidelines for the planned care. The effectiveness of counsellors is often dependent on how well the implementing organisation integrates them into the existing care system. They bear the responsibility for the actual implementation within their organization, but also for ensuring the quality of such care, which entails their active involvement in issues such as; supervision, guidelines, care standards, codes of conduct and impact assessment. Organisations need to be guided in the best way to deal with these issues and ideally follow a standardised approach. Additionally, the organisation's primary role lies in the crucial triad of identification-referral-treatment of mental health and/or psychosocial problems. To be effective in this role, implementing organisations should have the capacity to identify people who are distressed and be able to either deal with such clients internally, or refer them. Finally, caregiving organisations are in the best position to advocate for psychosocial counselling and bring it into mainstream care provision in Nepal.

Collaboration between organisations implementing psychosocial care. Collaboration between the implementing organizations, the donor community and the technical organizations, is essential. In the field of psychosocial care, collaboration could entail the exchange of information between the different organizations regarding clinical issues (e.g. peer supervision meetings) and the effectiveness of psychosocial interventions (e.g. what works well and what does not). The use of (peer) supervision meetings can assist organisations to fine-tune their counselling techniques and raise standards generally. Furthermore, collaboration should take place regarding advocacy and mainstreaming issues, especially raising of awareness, quality control and professional protocols. Lastly, collaboration regarding

inter-organizational referrals needs to be stressed. Currently, an initiative for such alliance is active, namely the Kathmandu Psychosocial Forum.

Discussion

Steps towards carrying out psychosocial interventions and mental health projects have been (scarcely) made in recent years in Nepal, and based on that experience some suggestions have been offered here. The article has tried to clarify the possible role of psychosocial interventions in Nepal, integrated and embedded in existing care interventions and structures, as well as to clarify how these measure up to culturally acceptable and international standards or critiques for psychosocial programmes for traumatized populations in non-Western countries. Some matters need extensive attention, for example, adequate working alliances between existing care professionals (e.g. traditional healers, psychiatrists), existing care systems (e.g. primary care agents) and counsellors. Newly trained people need to be strongly aware of the difficulties that could arise while working in this new profession. One should not start working without the support of people working in already existing professions. In addition, counselling is more likely to become accepted when it works with the assumption that the individual resiliency and community care and coping structures often are adequate instead of assuming that counselling is necessary for anyone we assume to be distressed.

Looking at the future of psychosocial counselling in Nepal, three parties seem to play an equally important role: the implementing organizations, the donor community (which will ideally be replaced by government agencies in the future) and technical agencies. In particular, implementing organisations hold the key towards integrating

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counselling. Not only in name or token but by ensuring that trained paraprofessionals are integrated, endorsed and supported within and by the organization as counsellors or psychosocial service providers with sufficient and correct mandate, rather than commonly found malpractices in this field in Nepal, such as providing counselling services without adequate training received, posting trained counsellors to non-counselling positions they had prior to receiving training or using counselling as a information collecting mechanism.

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Recommendations for the integration of psychosocial counselling in overall care settings in Nepal

1. Base interventions on client and community focused need assessments.
2. Awareness needs to be raised about psychosocial problems and interventions.
3. Make clear terms of reference, stating the responsibilities and tasks of the counsellor and thereby clarifying his role in the existing care system.
4. Include counselling within an holistic approach to care, which ideally entails multi-disciplinary teams and collaboration with other care professionals, including traditional healers and incorporate with overall child care and child development.
5. Counsellors should work together with primary care agents (parents, teachers etc.) for screening, treatment and encouragement for their vital role in any healing process, as well as including other existing social/cultural resources in the process.
6. Interventions should focus on normalization on the child's life, de-stigmatization, social reconnection, empowerment (e.g. increasing self-esteem, problem management skills, improve coping), reducing problem situations or the impact of such a problem situation, and providing an opportunity for expressions and sharing.
7. Ensure clinical supervision meetings.
8. Ensure adherence to and/or collaborate in the development of professional code of conduct; the counsellor is required to be aware of the organisation's rules and policies and follow them at all times, in particular rules of confidentiality. In addition to this the counsellor should maintain the professional standards and ethics of a counsellor⁸.
9. Create a council of counsellors (for quality control, protocols etc.).
10. Ensure adequate attention for care for care-givers.
11. Install internal/external referral mechanisms.
12. Ensure that impact of the psychosocial interventions is assessed.
13. Counselling should be embedded within a 'healing environment' and integrated with other clinical and non-clinical activities (Frederick, 2002).
14. Counsellors should have the availability of a comfortable and private room with necessary equipment (filing system, toys, art materials, etc.).
15. Review existing care system to adequately incorporate psychosocial interventions, as well as identifying necessary resources to do so.
16. Ensure that interventions are suitable to the (cultural) setting.
17. The counsellor should be aware of gender based issues and aim to raise organisation and community awareness of gender issues.
18. The counsellor should be aware of children's rights, protection and needs according to their age/ethnic background and take account of such issues when dealing with children.

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² In this paper we define 'psychosocial' as an approach that focuses on psychological well-being and/or mental health, which entails emotional, cognitive and behavioral stability, and it emphasizes the social environment (e.g. the children's existing social support systems and primary care-givers such as parents and school) of the children in terms of understanding the problem situation as well as in terms of problem-management, and lastly, it entails working from the significance and appropriateness given by existing culture and values

³ These training programmes have been aimed at training psychosocial counselling, that can be described by three principal components; (a) the beneficial effects of a therapeutic relationship, (b) providing emotional support, and (c) assisting with problem solving. Emotional support is to be achieved mainly through communication, listening, and counselling skills, empathising with the clients and the counsellor's attitude (e.g. attending, acceptance, encouraging). The latter refers to a process of counselling that clarifies the problem, identifies what the client wants as outcomes, assists the client in finding and implementing strategies to achieve those desired outcomes and thereby resolving or reducing the impact of an identified problem situation (including relaxation exercises, psycho-education etc.)

⁴ Do not describe such problems as psychiatric disorders, but as personal problems that are normal in the present situation

⁵ Reinhard defines *dhamis* and *jankris* as a person who at his will can enter into a non-ordinary psychic state (in which he either has his soul undertake a journey to the spirit world or he becomes possessed by a spirit) in order to make contact with the spirit world on behalf of members of his community (Reinhard, 1976)

⁶ Community implementation as described here and as being conducted by CVICT, entails a two step model of well-trained paraprofessional psychosocial counselors and volunteer community psychosocial workers, who jointly conduct the described activities.

⁷ Psychological first aid as a method to deal with recent trauma, without components of psychological debriefing that have been criticized (Raphael & Wilson, 2000)

⁸ Please note that rules of confidentiality have to be specified and should be the subject of a separate document signed by not only counsellors but all care providers within the organisation.

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