

Mental Health Services in New Nepal – Observations, Objections and Outlooks for the Future

Jha A,¹ Adhikari SR²

¹Nepalese Doctors' association (UK), Hertfordshire, UK, ²South Asia Forum on Mental Health & Psychiatry – Nepal Chapter, Department of Psychiatry, Kathmandu Medical College Hospital, Sinamangal, Kathmandu, Nepal

ABSTRACT

It has been over a decade since the government of Nepal adopted the National Mental Health Policy (NMHP) in 1997. This article analyses the current provision of fragmented mental health services in Nepal through case scenarios from Jumla in

northwest and Janakpur in southeast Nepal, criticises the proposed mental health Act, discusses the reasons why the NMHP has not been implemented and suggests future models of delivering mental health services in the wider community. Absence of a mental health section within the department of health, insufficient budget, chronic shortage of trained manpower, and unplanned growth of private medical institutions appear to be the issues deserving urgent attention. Setting up specialist psychiatric facilities in all developmental regions or future states, developing community mental health programmes and integration of mental health into general health care are the ways forward to meet the needs and expectations of the new federal Nepal.

Key Words: *community mental health, national mental health policy, Nepal, psychiatry*

INTRODUCTION

Nepal may be moving forward politically, but it is going backwards in its delivery of mental health care. The mushrooming of private medical colleges may give an illusion that each of them has a dedicated department to provide psychiatric training to their medical students, but the reality is different. Some of them do not even required number of psychiatrist in the department. At a recent mental health camp in Janakpur, it was dismayed by the absence of any psychiatric service for a population of over a million people. The nearest psychiatric hospitals were five hours drive-away at

Dharan and Biratnagar situated next to each other. Whose responsibility is it to address this glaring gap and inequality in the service provision? This article reflects on these issues and proposes new models of service delivery to suit the needs of people in federal and democratic Nepal.

A CLINICAL SCENARIO

Mr. Y, a 70-year old widower was brought by his youngest son to the Mental Health Camp recently held in Janakpur. He denied experiencing any problem and was puzzled to see a psychiatrist asking him very personal

Correspondence:

Dr. Arun Jha
Nepalese Doctors' Association (UK)
Hertfordshire Partnership NHS Foundation Trust
Logandene Care Unit, Ashley Close, Hemel Hempstead
Hertfordshire, HP3 8BL, UK.
Email: arunjha@hotmail.co.uk

questions. According to his son, Mr. Y's behaviour had changed in the last twelve months. He kept asking for the whereabouts of his 9-year-old grand son every few minutes. Once proud of his spotless kurta and dhoti, he would not wash his clothes for days. He would sit idle for hours pondering over trivial things and had many sleepless nights. The son was obviously worried about the gradual deterioration of his once very active and influential father. Understandably, he wanted to know what was wrong with his father and what could be done to help him. Was he depressed or dementing, or just getting old?

This is just one of several cases we saw at the 2-day mental health camp held recently at Janakpur on 23-24 September 2008. There were four psychiatrists expected to see over 200 patients in two days (16 hours). To see so many new patients in a limited period was a daunting task. In developed country like UK, a psychiatrist takes 45 minutes to interview, assess and discuss the treatment plan with patients and their relatives. At the camp we had only 15 minutes per patient. Even though there was no language or cultural barrier it was difficult to treat in short span of time. Assessment required more time to understand the details of his presenting problems, his background, personal and family history and his premorbid personality.

After spending half an hour, it became clear that Mr. Y was not showing any significant cognitive impairment and therefore not showing signs of a dementia. He was indeed suffering from a mild depressive illness against the background of his perceived failure in life and loneliness. In his younger days he used to be quite an influential local politician who had dreams of all his four sons to be rich and successful. Unfortunately, his eldest son was killed in a road-traffic accident four years ago; the youngest son remains unemployed at home, while the two middle sons had not contacted the family since they went to Qatar a year ago in search of good fortune. He felt helpless and bewildered. Mr. Y and his son deserved a longer consultation to discuss the role of antidepressant prescribed and the scope of a specific psychotherapy which was not available to him. We kept wondering about Mr Y's follow-up care. Who would review his progress? Who would monitor and adjust the dose of his medication? Would he afford to continue taking antidepressant at least for six months? What if his depression worsens and he becomes suicidal? What will happen to his 9-year-old grand son? This case highlights several problems regarding mental health service provision in Nepal at the moment.

MENTAL HEALTH SERVICES IN NEPAL – THE CURRENT SITUATION

Nepal is going through a period of fundamental transformation, shaking off its feudal past and

establishing a modern democratic state. The backdrop to the continuing social and political unrest affecting Nepal is deep seated poverty, poor governance and discrimination in the context of a highly stratified society, which has allowed opportunities to be restricted to a limited number by caste, ethnicity and gender. Although over the past decade poverty has been reduced from 43% of the population to 31% in 2004, Nepal remains South Asia's poorest country and the 12th poorest in the world.¹ Poverty levels are unevenly spread among ethnic groups and geographical regions. Nepal is the most unequal country in Asia, and the situation is rapidly worsening, which may fuel further conflict, provide a perfect breeding ground for antisocial activities, substance abuse, and common mental health problems including rising suicide rate.

Recent research shows that poor people in Nepal want jobs, first and foremost. Roads come next, followed by education and health, and then water. Although, health comes third in the priority list, mental health is not included in the Millennium Development goals. Child mortality, maternal health, and diseases like HIV/AIDS and malaria are at the top of national health priority list. There are no community mental health services (CMHS) apart from some basic training programme run by a voluntary organisation in seven out of 75 districts of Nepal. In other districts, despite the aspiration of Nepal's mental health policy formulated in 1996, CMHS are not available in the country, as mental health services are not yet integrated in the general health service system.² The Policy's first and foremost aim was to ensure the availability and accessibility of minimum mental health services for all the population of Nepal. Mental health service in Nepal is in a dire state; services are predominantly hospital-based, disorganised and urban-centred.³

Studies in Nepal have shown that at any one point in time at least 35% people in the community experience 'conspicuous psychiatric morbidity'.⁴ Substance abuse is on the rise in younger population. A recent survey of alcohol use by junior doctors and medical students has revealed that the prevalence rate of 'ever used', 'last year used' and 'last month used' were 64%, 57% and 43% respectively.⁵ Besides suffering from alcohol related medical and psychiatric disorders, future generation of our doctors are failing to be good role models for our youngsters. There are no specialist child or old age psychiatric services in Nepal. Mental health problems are becoming noticeable in the growing elder population. A recent study has reported that nearly one in five people older than 60 years has a diagnosable psychiatric disorder.⁶ Furthermore, these elders were also less likely to receive assistance with the disability they reported, compared to their healthy counterparts.

A recent editorial in the Journal of Nepal Medical

Association⁷ comments on the first 300 deaths recorded in spring 2008. Among suicidal deaths, hanging (47/300) and poisoning (41/300) were the two most common methods used. The answer suggested to the question, 'are these preventable?', was 'timely referral to psychiatric evaluation and possible treatment of suicide-prone patients could indeed prevent at least some of these deaths'. One would fully agree with those remarks but timely referrals are only possible if psychiatric facilities exist in most parts of the country.

According to the largest international psychiatric epidemiological study so far, unmet needs for mental health treatment are especially worrying in low-income countries.⁸ The study revealed that at least two-thirds of people who are mentally ill receive no treatment. The WHO World Mental Health Survey Consortium⁹ surveyed six less developed and eight developed countries to estimate prevalence, severity, and treatment of common mental disorders in 2001-2003. One of the shocking finding was that more than two-third of serious cases in less-developed countries received no treatment in the 12 months before the survey. Reallocation of treatment resources could substantially decrease the problem of unmet need of those cases, but Nepal has no room to manoeuvre because of non-existence of any meaningful budget in mental health sector.

MENTAL HEALTH AWARENESS ACTIVITIES

Improving awareness of mental health and related problems is a global challenge for the professionals and planners all over the world. This is one of the key components of Nepal's mental health policy. Has the ministry of health done any thing about it? Not really. Less than 1% of health care expenditures by the government are directed towards mental health.² To be precise, only 0.02% of total health budget was allocated for mental health in 2008. There is no regulatory body to monitor mental health facilities and impose sanctions on those that persistently violate patient's rights. The condition of the only national mental hospital in Lagankhel has been pathetic due to inadequate manpower, shortage of physical facilities and equipments, and absence of canteen service, pharmacy, emergency psychiatric services and lodging facility for family members. In contrast, only a few meters away, the mission hospital is equipped with all modern facilities to provide the state of art medical services. This is just one example of the extreme discrimination psychiatric services are experiencing in Nepal.

The World Psychiatric Association has recently produced an Action Plan for consisting of ten institutional goals.¹⁰ The first goal is to enhance the image of psychiatry worldwide among the general public, health professionals and policy makers, and the second goal is

to improve the quality of mental health care, education and research worldwide. The South Asia Forum on Mental Health & Psychiatry (SAF-Nepal) and the Nepalese Doctors' Association UK (NDAUK) have joined hands in raising awareness and improving the quality of mental health in Nepal. We declared 20-26 September 2008 as the mental health week and organised a series of activities during that period (figure 1). For the first time in the history of Nepal they have celebrated the World Alzheimer's Day on 21 September. Despite an unexpected strike in Kathmandu valley due to a local religious controversy, over 300 participants took part in a memory walk stretching from the International conference centre to the Mandala square. People from all walks of life ranging from school children to senior citizens were present on that Sunday autumn morning. Representatives from over 18 social and voluntary sector organisations were led by the officials from Alzheimer's Association Nepal and SAF-Nepal. In the afternoon, the National Senior Citizen Organisation Network organised a special workshop on Alzheimer's disease. Several articles on dementia were published in various national daily and weekly news papers during that week.

The SAF-Nepal & NDA (UK), in collaboration with Janki Medical College and Dhanusha Red Cross Society, organised a 2-day mental health camp in Janakpur on 23-24 September (Figure 1). Psychiatrists from Kathmandu, Dharan, Birgunj and UK managed to examine nearly 100 patients and raised public awareness through local radio interviews. We were also able to announce the opening of a community mental health resource centre to be launched in January 2009. That will be the first resource centre of its kind to run a day care service along with monthly outpatient clinic and depot clinic for people with mental health problems in Janakpur and surrounding area. The Janakpur mental health pilot project may pave the way for a new and unique kind of community mental service in a low-income country.

QUALITY OF PSYCHIATRIC SERVICES

A few Physicians in Kathmandu and Janakpur made some striking remarks about the current psychiatric practices of our colleagues. For example, 'when we refer patients to psychiatrists, they come back within a few minutes', 'why do psychiatrists always prescribe all sort of psychotropic drugs for each and every patient?' These are serious allegations against our psychiatrist colleagues in Nepal. We are not sure whether these comments are valid as we have not conducted any survey to substantiate these claims. Nevertheless, if that is the perception amongst our medical colleagues, we have to review our current practice and postgraduate psychiatric training programme.

We believe that our psychiatrists are well trained and qualified to provide psychiatric services and training,



Figure 1. Highlights of the mental health Week in Kathmandu and Janakpur on 20-26 September 2008

but there are not enough of us. If we have to run busy outpatient clinics where less than 15 minutes are allotted for each new patient, quality of service would suffer. Psychiatrists need more time to carry out a comprehensive psychiatric assessment. Interview is the tool our trade, listening is our stethoscope, mental state examination our laboratory tests and cognitive examination our special investigations. These activities require time and resources. Hospitals and employers should limit the number of new and follow-up patients seen each day. The number of clinic may have to go up to provide quality service. Hospital psychiatry has to be backed up by community psychiatry services. Services have to spread out from the city to the community.¹¹ Every district hospital has to have psychiatrist to coordinate and support mental health services in the community. Similarly, faculty members in teaching hospitals need even more time to teach and train postgraduate students, who in turn should not be under pressure to provide clinical services at the cost of their training and academic activities. Challenges faced in building nation-wide community mental health care in developing countries are manifold. One of these

challenges is the need to decrease the amount of time devoted to individual clinical care and increase the time for training of other personnel. This is a big challenge for clinicians who value caring for ill people by themselves. This change in role becomes meaningful when we recognise that training of other personnel has a multiple effect on mental health services for the population.¹²

MENTAL HEALTH LEGISLATION

Imagine a scenario of a young man in Jumla suddenly starting shooting government officials randomly in the mistaken belief that the present government is going to ruin the country for ever. What would happen to him? Chances are that he would be caught by local people, and eventually arrested by the police and presented before a court with murder charge. Who would decide whether the young man is a political activist, a terrorist or mentally ill? If mental illness is suspected he would require treatment. What if he denies illness and refuses treatment? In developed countries, these people are assessed by mental health professionals and, if found to be mentally ill, they are detained against their will

under the mental health act in a psychiatric facility for further assessment and treatment for a specified period of time. Currently, Nepal does not have a mental health Act, and there are only a few such psychiatric facilities in Nepal outside Kathmandu. Similarly, there are no psychiatric services in any prison and no separate forensic psychiatric service in the country.

In 2006, a committee of mental health professionals and legal experts in Nepal drafted a Mental Health Act (MHA, 2006) “to rehabilitate people with mental disorders in the society by providing timely care and safeguarding fundamental rights of people with mental disorders”.¹³ That was a very bold attempt to address an important gap in the national mental health service, but unfortunately the whole exercise was fraught with serious shortcomings.

Mental Health Act for a low-income country is like an elephant at a poor man’s home. A country where even essential medical and psychiatric facilities are not available, how can it afford a piece of legislation which requires enormous man power and systems in place to implement and maintain the spirits of the mental health act? Moreover, the Act was drafted when Nepal was a kingdom where every thing was centralised. With its imminent transformation into a federal republic the new Nepal demands total decentralisation of services and systems. The Draft MHA, 2006 proposes to convert the Lagankhel Mental Hospital into a ‘National Mental Health Centre’ to provide ‘specialised services in the mental health’. To propose just one central specialist psychiatric hospital for a population nearly 30 million people of Nepal is not in keeping with the current national spirit. There has to be at least one specialist hospital in each region. People from Mechi to Mahakali and from Jumla to Janakpur should have access to specialist psychiatric facilities as close to their home as possible. To transport acutely psychotic patients from different parts of the country to Lagankhel under mental health act is neither possible nor desirable. The young man from Jumla and the old man from Janakpur deserve the same treatment as people in the capital. Before having a mental health act, Nepal needs a national community mental health programme for the entire country.

COMMENTS AND FUTURE DIRECTION

The fate of the Jumla young man remains in balance. Chances are that he would neither receive justice nor psychiatric help. He might be beaten up by local political gangs until he dies or he may join another gang in revenge. At the other side of the country, Mr. Y will take the antidepressant only till it runs out in a month, because he was not convinced he was depressed or

may not afford the prescription for another five months. He may improve initially but he would not reach remission. If he does not commit suicide, he would continue suffering and continue asking for his grand son. He would also be labelled as an old man ‘losing his head’. His grand son would grow up deprived of his grandfather’s proper love and affection. Mr. Y’s mood and memory would have improved had he received the minimum mental health service as promised in the Nepal’s national mental health policy over a decade ago. Alternatively, Mr. Y may have responded to an appropriate psychotherapy. We are not talking about the fancy cognitive behaviour therapy developed in the west, but simple support, skilled listening and a course of meditation developed by Gautam Buddha in our own land! Home grown psychotherapeutic techniques may be more effective for the majority of Nepalese population at a very little cost.

The only way forward is to train the existing primary care health workers in the common and treatable psychiatric conditions in every district of the country. Currently, our postgraduate psychiatric institutes are producing on average only four psychiatrists per year. Most of these products are absorbed by the private medical colleges. How can we think of sending psychiatrists at all 75 district hospitals when only 4 out of 14 zonal hospitals have a psychiatrist in post? Health planners and policy makers have to pay attention not only to the medical needs of the general population but also to their mental health needs.

In our view, this state of affairs is unlikely to change unless the Ministry of Health establishes a dedicated department or section of mental health with sufficient ring-budget ring fenced for mental health services. The way forward is the integration of mental health into general health care, and the utilisation of non-specialist personnel for a wide variety of mental health tasks, including suicide prevention, disaster psychosocial care, drug dependence care, rehabilitation, care of persons with mental retardation and schizophrenia, public mental health education, and mental health care in children and in the elderly by sharing the experiences of building community mental health care in other developing countries.¹² There is no health without mental health.

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