Access to Mental Health Care in Nepal: Current Status, Potential Challenges, and Ways Out

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Abstract Nepal is a small Himalayan nation situated between India and China. The history of mental health care development in Nepal is around 60 years. The burden of mental health issues is high and resources are limited. Though there has been steady improvement in mental health care services, Nepal faces challenges similar to other lower middle income countries and some unique ones. The major challenges in mental health care in Nepal are high treatment gap, unregulated help seeking pattern, poor fund and research, inadequate and inequitable manpower, huge out of pocket expense, poor referral system, poor mental health literacy, high stigma, non-judicious prescribing and various administrative difficulties. In this chapter we discuss about the historical aspects, epidemiology, policies and legislations, services, challenges and potential ways out for mental health care in Nepal.

Keywords Nepal · Mental health care · Psychiatry · Mental health challenges · Treatment gap · Ways out

1 Introduction

Nepal with an area of 147,181 km^2 and a population of approximately 30 million, is located in South Asia and shares territorial borders with India and China. It is one of the eleven member states of WHO south East Asian region. Nepal became a republic, federal state after the promulgation of the constitution in 2015. The history of health development in Nepal has been summarized into four periods; 1951–1970:

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the early health development programs of disease eradication after the end of the Rana oligarchy; 1970–1990: the turn to primary health care during the Panchayat; 1990–2010: the rise of non-governmental organizations (NGOs) after the People's War; and 2010–present: the return to health systems development in the post-conflict and post-disaster period (Seale-Feldman, 2019; Table 1). Unlike most of the countries, Nepal never had a mental asylum, and mental health services started out in general hospital settings in Nepal. The first out-patient service in psychiatry was started in 1962 and in-patient treatment service was started in 1965 (Upadhyaya, 2015). However, before that patients with severe mental illness would go to Ranchi Mental hospital, Gorakhpur or Lucknow i.e. cities of India for treatment. Male patients having psychosis with or without criminal background were kept in Dhulikhel Jail whereas female patients were kept in the Central Jail of Kathmandu (Upadhyaya, 2015). With time, there was a slow and steady improvement in the mental health sector of Nepal. Community mental health services started in Nepal in the 1980s under the leadership of the NGOs like United Mission to Nepal (UMN) whose main aim was to train health personnel in order to provide mental health services at primary care level. The notable five-year pilot project of 1984 turned out to be successful and the model was replicated by government academic institutions (Singh et al., 2022). Subsequently, several academic courses like Doctor of Medicine (MD) i.e. post graduate in Psychiatry was initiated for the first time at the Institute of Medicine (IOM) in 1997. A 2-year MPhil programme in clinical psychology was started in 1998 and in 2000, a program in psychiatric nursing was started. The National Mental Health Policy was developed and endorsed by Ministry of Health in 1997 (Shyangwa & Jha, 2008).

Table 1 Historical landmarks in mental health in Nepal (Shyangwa & Jha, 2008; Upadhyaya, 2015)

Year	Landmark events
1962	Psychiatric OPD services started
1965	Psychiatric in-patient services started
1976	Narcotic drugs control act was framed
1976	Rehabilitation center for drug abusers started by NGO sector
1984	Central level mental hospital started
1984	Community health development project (CDHP) in Lalitpur by UMN
1989	Mental Health project started at IOM, financial aid of NGO
1997	National mental health policy and plan developed and adopted by the Ministry of Health
1997	MD psychiatry training started
1998	M.Phil in clinical psychology started
2000	Psychiatric nursing courses started

2 Epidemiology and Burden of Mental Illness in Nepal

Mental disorders were ranked as the second leading cause of years of healthy life lost due to disability (YLDs) in Nepal (Mishra et al., 2020). Among the South Asian countries, Nepal ranks second in prevalence rate (307 per 1000) of psychiatric morbidity as per a review (Ranjan & Asthana, 2017). Suicide in Nepal also has become a major public health concern due to increasing rates and high burden (Thapaliya et al., 2018). The first National Mental Health Survey (NMHS) of Nepal was conducted in 2019–2020 with a sample size of 15,088 (9200 adults and 5888 adolescents i.e. 13–17 years) in seven provinces of Nepal. The survey used International Neuropsychiatric Interview (MINI) for psychiatric disorders, version 7.0.2 for Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) for both adults and kids. It was translated and adopted in Nepali language (Dhimal et al., 2022). The wards were taken as Primary Sampling Units (PSUs) and were selected from each of the seven provinces of Nepal using a multi-stage Probability Proportionate to Size (PPS) sampling technique. From each PSU, the list of households was obtained and then the individual members from each household were listed. Individual participants from the household who were selected using a systematic sampling technique were taken as Secondary Sampling Units (SSUs). The major findings have been presented in Table 2. Before the main survey, a pilot survey was conducted among 1647 participants including 276 children aged 13–17 years and 1371 adults aged 18 years & above, in three districts of Nepal: Dhanusha, Bhaktapur and Dolakha using the same tool. The three districts taken represented three ecological regions of Nepal. In the pilot survey the prevalence of current mental disorders among adults and children were 13.2% and 11.2% respectively. The prevalence of current suicidality was 10.9% among adults and 8.7% among children (Jha et al., 2019).

A nationwide cross-sectional study among a representative sample of Nepalese adults between the age of 18 and 65 years with a sample size of 2100 selected by multistage random cluster sampling using Hospital Anxiety and Depression Scale (HADS), to detect cases of anxiety (HADS-A), depression (HADS-D) and comorbid anxiety and depression (HADS-cAD) found the age- and gender-adjusted point prevalences of HADS-A, HADS-D and HADS-cAD to be 16.1, 4.2 and 5.9% respectively (Risal et al., 2016). There have also been prevalence studies conducted in different vulnerable populations in Nepal. A systematic review of 26 studies on the prevalence of mental disorders in geriatric population showed a prevalence of depressive symptom in a range of 25.5% to 60.6% in the community. The prevalence ranged from 17.3 to 89.1% in aged-care facilities and it was in the range of 53.2–57.1% in hospital settings. The prevalence of depressive disorders varied between 4.4% in community sample and 53.2% in hospital sample. The prevalence of cases of anxiety symptoms ranged from 21.7 to 32.3%. The other identified disorders in this group were psychosis and alcohol use disorder (Thapa et al., 2018). A review on prevalence of mental disorders among Bhutanese refugees in Nepal showed high incidence of mental disorders including anxiety, depression and post-traumatic stress disorder in both tortured and non-tortured participants (Kane et al.,

Table 2 Findings of National Mental Health Survey, 2019/20 (Dhimal et al., 2022)

Disorders	Lifetime % (95% CL)	Current% (95% CL)
Adults		
Any mental disorder	10.0 (8.5–11.8)	4.3 (3.5–5.2)
Schizophrenia and any psychotic disorders	0.2 (0.1–0.3)	0.1 (0.1–0.3)
Bipolar affective disorders	0.2 (0.1–0.5)	0.1 (0.1–0.3)
Depressive disorders	2.9 (2.3–3.7)	1.0 (0.8–1.4)
Anxiety and stress related disorders	–	3.0 (2.5–3.6)
Suicidality	–	7.2(5.9–8.8)
Adolescents		
Any mental morbidity	–	5.2 (4.2–6.4)
Bipolar affective disorder	–	0.2 (0.1–0.4)
Depressive disorders	–	0.6 (0.4–1.0)
Anxiety and stress related disorder	–	2.8 (2.0–3.8)
Any psychotic disorder	–	0.3 (0.2–0.6)
Behavioural and emotional disorder	–	1.0 (0.7–1.4)
Suicidality	–	4.1(3.3–5.2)

2018; Mills et al., 2008). Among the children population a scoping review showed that the prevalence of emotional and behavioural problems in children going to school was in the range of 12.9 and 17.03%. The prevalence of Autism Spectrum Disorder (ASD) was estimated to be three in every 1000 persons. Similarly, prevalence of anxiety disorders ranged from 18.8 to 24.4% and Attention Deficit Hyperactivity Disorder (ADHD) ranged from 10 to 11.7% in different clinical samples of children and adolescents (Chaulagain et al., 2019). A study among 66 sex trafficking survivor females staying in two NGOs showed that 87%, 85.5% and 29.7% of the sample scored above anxiety, depression and PTSD thresholds, respectively which is very high (Rimal & Papadopoulos, 2016).

Nepal went through a decade long conflict from 1996 to 2006 and experienced a mega earthquake in 2015. It has been seen that this has led to an increase in mental health and psychosocial issues (Tol et al., 2010). A study done among 720 adults in the post conflict scenario using a three-stage sampling following a proportionate stratified random sampling found out that 27.5% of the sample met the threshold for depression. Also 22.9% of sample met the threshold for anxiety, and 9.6% of sample met the threshold for PTSD (Luitel et al., 2013). A study among 513 participants four months after the mega earthquakes using stratified multistage cluster sampling in three earthquake affected districts in Nepal showed that one out of three adults reported of having symptoms of depression and distressing levels of anger, one out of five adults engaged in problem drinking, and one out of ten participants had suicidal thoughts (Kane et al., 2018). Among the children population a prevalence of Post-Traumatic Stress Symptoms (PTSS) ranging from 10.7 to 51% of earthquake-affected areas in the Kathmandu district of Nepal was seen. A study done in former

child soldiers during Maoist insurgency reported that 53.2% met the cut-off score for PTSS (Chaulagain et al., 2019).

3 Mental Health Policy and Legislation

The Constitution of Nepal has made a provision for free basic health services and equal access to health services for every citizen under the rights relating to health. The list of basic health services includes Mental health care in Section 4 (e) of Section 3 of the Public Health Services Act, 2075 (2018) (Nepal Law Commission, 2018). Similarly, mental health services have been included in the 'basic and emergency health services' in Schedule 1 and 2 of the Public Health Regulations 2077 (2020), and service arrangements for mental health to be made at the federal, the provincial, and the local levels are in place (Department of Health Services, 2020).

The Government of Nepal's 15th Five-Year Plan (2019/20–2023/24) also includes a plan to expand access to mental health services at all levels. The government has implemented an action plan including mental health initiatives in line with the Multisectoral Action Plan for the Prevention and Control of Non-Communicable Diseases (2014–2020). The action plan emphasizes a concrete mental health strategy that needs to be formulated and implemented in line with the constitution, national health policy, and federal governance system (National Planning Commission, 2023). The National Health Policy, 2076 (2019) allows for the existing policies to be repealed after the issuance of the detailed thematic strategy (Department of Health Services, 2020).

Currently, there is no standalone mental health policy but is governed by the National health policy which is the single over-arching policy with different subsections for different health conditions. Mental health is mentioned in Sect. 17.5. The National Mental Health Strategy and Action Plan (2020) provides a comprehensive description of action plans for mental health care in Nepal. This strategic action plan describes the provision of free mental health services in primary care in all parts of the country. The major aims of this action plan are-integration of mental health in primary care setting, inter-sectoral coordination among government, private and NGO sector and right based all-inclusive mental health provision for all. For achievement of these aims, the following strategies and action plan are made (*WHO*, 2021):

1. Ensure easy, affordable, and equal access to mental health services for all.
2. Arrange the means, resources, human resources, and mechanisms required for the delivery of mental health and psychosocial services.
3. Increase public awareness to promote mental health and eradicate existing superstitions, myths, and misconceptions.
4. Protect the basic human rights of people with mental health problems and psychosocial disabilities.
5. Integrate the information related to mental health services into the existing health information system and promote study and research on mental health.

Regarding substance use disorders, the treatment and rehabilitation are based on the Ministry of Home Affairs' Directive on the Operation of Treatment and Rehabilitation Center for the Users of Narcotic Drugs, 2018 and National Opioid Substitution Therapy Guideline 2013. The national policy documents have envisioned to develop a National Standardized Treatment and Rehabilitation Protocol for alcohol and substance use disorder in Nepal. The Narcotics Drug Prevention and Control National Master Plan 2022–2027 has envisioned to develop a "Accepted Standard Training Curriculum" to train existing service providers (Ministry of Home Affairs, 2022, 2023). Additionally, the "Directive on the operation of treatment and rehabilitation center for the users of narcotic drugs, 2018" also recommends treatment based on "National Treatment Protocol" (Pant et al., 2023).

Though there is a perception of criminality associated with suicide, attempted suicide was never criminalized in Nepal. However, the new Criminal Code (2017) of Nepal criminalizes the abetment of suicide. Section 185 Prohibition on Abetment of Suicide states: (1) "No one should provoke or generate a situation abate anyone to commit suicide or to create circumstances compelling someone to commit the same. (2) Anyone found guilty under the clause is liable to a five-year jail sentence and Rs 50,000 fine" (approx. $405 USD) (Utyasheva et al., 2022).

There is no mental health act in Nepal till now. However, few acts of Nepal are activated regarding the mental illnesses. Chapter 7 of the Act Relating to Rights of Persons with Disabilities, 2074 (2017) provides for every citizen's right to health, rehabilitation, social security, and recreation. Sections 35 and 36 of the Act also ensure additional service facilities for people with mental or psychosocial disabilities (Nepal Law Commission, 2017).

4 Available Mental Health Services and New Avenues in Nepal

4.1 Governance

The Ministry of Health & Population (MoHP) overall leads mental health services in Nepal. Under the MoHP, the Department of Health Services (DoHS) is responsible for coordinating and providing mental health services at a public level. Within the DoHS, the NCD and Mental Health Section of the Epidemiology and Disease Control Division (EDCD) acts as the focal agency for mental health and takes on various responsibilities, including planning and organizing services, collaborating with other government and non-government sectors, and implementing national plans and programs related to mental health. Moreover, the Curative Service Division of DoHS is in charge of managing mental health services at secondary and tertiary care level. On the other hand, the Management Division of DoHS oversees the Health Information System and supply of psychotropic medications. The National Health Training Centre (NHTC) identifies training needs, develops and accredits training

curricula accordingly, and organizes training sessions to specific cadres of health care providers based on the accredited training modules. Similarly, the National Health Education Information and Communication Centre (NHEICC) within the DoHS acts as the focal division to prepare and widely disseminate information, education and communication (IEC) materials on mental health in Nepal. The Nursing and Social Security Division of the DoHS acts as a focal division for mobilization of nurses (including the recently introduced school nurse program who are envisioned to conduct school mental health prevention and promotion programmes).

4.2 Help Seeking Behaviour for Mental Illness

The help seeking for mental disorders is varied in Nepal as per geographical location as availability is not equal in all parts of Nepal. The help seeking ranges from faith healers, supernatural role practioners, general practioners, community health workers to mental health professionals. Faith healers are the first contact in most of the cases in comparison to the psychiatrist as they are easily approachable and people have belief in supernatural cause for mental disorders (Pradhan et al., 2013). A 14 center nationwide study found out most of the patients with severe mental illnesses (SMIs) had their first contact with faith healers (49%). 29.8% of patients with common mental disorders (CMDs) had first contact with faith healers and 26% of the patients had first contact with psychiatrists. The duration between the onset of illness and the first carer visit was 30.72 ± 80.34 (median:4) weeks which is higher when compared with the global data (Gupta et al., 2021). The National Mental Health Survey 2020 showed that among the people who had sought for treatment, it was found that non-specialist doctors (8.8%), faith healers (6.7%) and psychiatrists (6.5%) were the service providers sought for treatment (National Mental Health Survey, 2020).

4.3 Mental Health Services

The mental health care delivery system in Nepal is decentralized. It comprises a mix of public health facilities, private sector service providers and the involvement of NGOs at federal, provincial and local levels. Basic and emergency health facilities include basic health service centres, basic hospitals, general hospitals, specialist and specialized hospitals, teaching hospitals under the Institute of Health Sciences, Ayurveda service centres, specialist Ayurveda hospitals and homeopathy hospitals and polyclinics. Mental health care is provided mainly at the secondary or tertiary level, at one specialist public–private psychiatric hospital and four private psychiatric hospitals. Mental health care is also provided for inpatients in many of the 364 private general hospitals and 27 Government hospitals in the country (*WHO*, 2021). There is only one out-patient mental health unit for children and adolescents in Nepal which is

at Kanti Children's Hospital, and there is no dedicated inpatient facility (Chaulagain et al., 2019). Majority of mental health services are delivered by specialists.

There are 19 medical colleges in Nepal both public (5) and private (14). All of these academic institutions have the Department of Psychiatry. There are ongoing post graduate courses in Psychiatry (MD psychiatry) in almost all medical colleges. Two academic institutions are running the courses of MPhil in clinical psychology. There are five different post-graduate training programmes of psychiatry as per the affiliation to the universities but the curriculum and evaluation process of the training is not uniform. There are about 45 residents in psychiatry training currently. Also, the undergraduate curriculum of Nepal varies from medical schools in the four Lower and Middle Income Countries (LMICs) of South Asia like Bangladesh, India, and Sri Lanka (Arafat et al., 2021). There are considerable disparities in course content teaching/learning modalities and modalities of assessments for psychiatry curriculum across medical universities in undergraduate level within the country,. Also, the relative proportion of psychiatry as a subject in medical curricula as well as teaching/learning and assessments as a proportion to whole curriculum are far below ideal (Marahatta et al., 2021).

The Government of Nepal aims to fulfil the treatment gap through task sharing approach by training the health care providers as well. Services range from community level case screening and referral by Female Community Health Volunteers (FCHVs) using the Community Informant Detection Tool (CIDT) for basic emotional support by community based psychosocial workers (CPSWs); basic psychosocial support by paraprofessional counsellors; diagnosis and management of common mental disorders by trained government health care workers to Psychiatric services at general hospitals and Psychiatric hospitals (Luitel et al., 2020). The mental health resources have been summarized in Table 3.

Table 3 Mental health resources of Nepal in 2023 (*WHO*, 2021; Rai et al., 2021)

Health budget as a proportion of national budget 2023/24	5.87%
Estimated annual budget for mental health interventions (excluding human resources and hospital operations)	USD 1.5 m
Per capita public funds allocation for mental health	Approx. 0.05 USD
Number of registered psychiatrists	250
Number of child psychiatrists	4
Number of registered clinical psychologists	37
Number of lay counsellors	Approx. 1300
Number of psychiatric nurses	Approx. 75
Number of districts with fund allocation for mhGAP training in 2023	77 (all districts)

4.4 Mental Health Gap Action Program (MhGAP) in Nepal

The World Health Organization (WHO) launched the Mental Health Gap Action Programme (mhGAP) and the mhGAP Intervention Guide (mhGAP-IG) for mental, neurological and substance use disorders with the aim of providing evidence-based clinical guidance to primary healthcare workers (WHO, 2010). The first version of the mhGAP-IG (V1.0) has been translated, adapted and implemented in over 100 countries (Keynejad et al., 2018). An updated version of the mhGAP-IG (i.e. V2.0) was launched by WHO in 2016 (WHO, 2016). WHO mhGAP was first tested by the PRogramme for Improving Mental health carE (PRIME) project (Lund et al., 2012) which included a consortium of five low and middle income countries in Asia and Africa, one of which was Nepal. The evaluation results of mhGAP demonstrated that the detection of depression by mhGAP-IG trained primary healthcare workers increased by 15.7% (from 8.9 to 24.2%) 3-month after the training but these rates again dropped to 10.2% twenty-four months after the training (Jordans et al., 2019).

Later, the mhGAP-IG (V2.0) was translated and adapted under the leadership of National Health Training Centre (NHTC). The adaptation and testing of WHO mhGAP in Nepal opened an avenue for task-sharing approaches on mental health and psychosocial support (MHPSS). Consequently, the following training modules targeting various cadres of medical practitioners and paramedic professionals have been endorsed, accredited and in vogue in the country:

- Module 1: This training module aims to build the capacity of nurses on provision of-psycho-education to disorders included in the adapted Nepali version of WHO mhGAP; basic psychosocial support and behavioural activation for depression. This is a 6-day training but includes an optional module of 2 days on counselling for alcohol problem (CAP) as well.
- Module 2: It has been further splitted into Module 2a (training module for medical doctors) and Module 2b (training module for paramedic professionals). This training module is based on the Nepali adapted version of WHO mhGAP V2 for mental, neurological and substance use disorders in non-specialized settings. This is a 5-day training. Additionally, this module also contains the curriculum for training of trainers (ToT). This training builds the capacity of healthcare providers on assessment, management, treatment, follow up and referral of patients with MNS disorders.
- Module 3: This training module targets medical doctors, nurses and paramedic professionals. This is a 5-day training on assessment, management, follow up and referral of children and adolescents with developmental, behavioural and emotional disorders.
- Module 4: This training module aims to build the capacity of female community health volunteers (FCHVs) on screening and referral of individuals with MNS disorders in the communities. This is a 2-day training and uses standard validated community informant detection tool (CIDT) for screening of mhGAP disorders.
- Module 5: This training module aims to build the capacity of public health professionals including managers and administrators on conceptualization, designing,

implementation and evaluation of community based mental health programmes. This is a 2.5-day training.

- Module 6: This training module is basically derived from the para-professional counsellor training developed and used by several non-government organizations working on MHPSS in Nepal. This training targets health assistants and nurses within the government health care delivery system. It runs in three phases-basis, advance 1 and advance 2, each lasting for 10 days. The participants of the training must appear in online tests and evaluation and must complete the field assignments before accreditation.

4.5 Newer Avenues

Telepsychiatry in Nepal also has gained popularity after the COVID-19 pandemic. Many government hospitals and private sectors seemed motivated, and utilized telepsychiatry as a medium of service in Nepal (Singh et al., 2022) which is being continued in the current context as well. A perspective article from South East Asia involving 52 respondents (medical students, psychiatry trainees and early carrier psychiatrists) showed a lack of theoretical and practical training on newer digital tools and digital health interventions in psychiatry. And a need of implementing psychiatry training programs integrating digital tools properly adapted to the digital era was felt (Orsolini et al., 2021). A study from eastern Nepal among 104 patients (73 follow-ups and 31 new) showed that telepsychiatry is a feasible and viable option for mental health service delivery in Nepal (Shakya, 2021). There are 24 h suicide help lines run by government hospitals like Mental Hospital Lagankhel, Patan Hospital, Tribhuvan University Teaching Hospital and NGOs in Nepal. One of the important example is the crises line "1166" run by the Mental Hospital Lagankhel under the technical and financial support of WHO and Transcultural Psychosocial Organization Nepal (TPO Nepal) (WHO, 2022).

A unique concept implemented considering the treatment gap in Nepal is the 'Satellite Clinic'. These clinics are conducted as outreach clinics in rural parts of the country by Psychiatrists to provide specialized out-patient services to people either monthly or bimonthly. A local pharmacy or a community health center hosts these outpatient services. There is nominal consultation fee of three to five USDs for each patient (Sharma et al., 2020).

The newer neuromodulation techniques like rTMS, HD-tDCS have also been started in Nepal in recent years in both public and private sectors.

5 Challenges in Mental Health Care in Nepal

Challenges faced by Nepal in mental health care almost resemble those faced by other LMICs. These include mental health being kept as a low public-health priority agenda and subsequent minimal funding; resistance to decentralization of services; challenges in integration of mental health care in primary-care settings; the low numbers of workers who have received training and supervision in mental health care; and the frequent scarcity of public-health perspectives in mental health leadership (Saraceno et al., 2007). The following are the major challenges that Nepal faces in mental health care:

5.1 High Treatment Gap

The disease burden of mental illnesses is high and the resources are limited. Though the Government of Nepal aims to fulfil the treatment gap through task sharing approach by training the health care providers, the case detection rates are quite low considering the lack of awareness, inadequate capacity building of health care providers, irregular supply of psychotropic medications, inadequate mental health budget, etc. These have resulted in difficulty with mental health service delivery through the government health care system (Upadhaya et al., 2017). A community based study using three-stage sampling technique among 1,983 adults from 10 Village Development Committees (VDCs) of Chitwan district showed 90% of the participants didn't participate in the treatment for depression and alcohol use disorder; and major barriers to care were fear of being perceived as "weak" for having mental health problems, lack of financial means to afford care,, fear of being perceived as "crazy" and being too unwell to ask for help (Luitel et al., 2017).

5.2 Unregulated Help Seeking Pattern

A scoping review of 86 studies from Nepal covered a wide range of diagnostic and treatment strategies by faith healers like divination, recitals, spoken and non-spoken rituals, pulse checks, offerings, and altered states of consciousness which were all non-medical and not based on any proven intervention. This didn't depend upon exact technique, making this a major challenge in management (Pham et al., 2021). They are an important part of the belief system and may act as barriers at times for evidenced based medical intervention. Most of the patients with severe mental illnesses (SMIs) contact faith healers and have a high duration of undertreated illness ranging from weeks to years (Gupta et al., 2021).

5.3 Poor Fund and Research

The allocation of budget for the health sector in Nepal is 5.87% and the chunk available for Mental health sector is low. The national funding for research is low. The research from developing countries have been criticized for being donor-driven, focused on non-significant problems rather than major psychiatric disorders, catering to the priorities of external donor agencies, being poor quality, not being well documented, not being disseminated and put to use by policy makers at all levels and sectors of society. The same is true for Nepal (Sharma & Subedi, 2019).

5.4 Inadequate and Inequitable Manpower

The resources available to cater the need of whole nation is very less. Around 250 psychiatrists and 37 psychologists for a nation of 30 million populations is inadequate. Also, the psychiatrists are available in the major cities and majority of patients have to travel a long distance to avail the services.

5.5 Huge Out of Pocket Expense

A population based survey of 2040 adults showed that people with symptoms of depression utilize more healthcare and spend greater out of pocket costs compared to people without depression. The major chunk of money was utilized for frequent visits to pharmacists and visits to general and specialist doctors, however, there was minimal use of specialist mental health services (Rajan et al., 2020). As per the National Mental Health Survey, 2020, the patient with mental disorder had an average expenditure of NRs 16,053 for the treatment in the past 12 months. The expense on transport and other costs associated with seeking treatment was NRs 4,146 and NRs 3,460 respectively (1 USD = 130 NRs). These are significant expenditures considering the low per capita of the country. This huge out of pocket expenditure without major achievement acts as a challenge in our context (National Mental Health Survey, 2020).

5.6 Malfunctioning Referral and Reporting System

The referral to mental health services is late either by the faith healers or the general practioners. Also there is lack of a formal referral mechanism from primary to secondary/tertiary care or vice versa (Luitel et al., 2015). Another challenge in mental health care is data keeping and reporting. Though mental disorders are reported on

the national HMIS through a web portal from all government health facilities, due to low case detection rate and lack of knowledge among all health workers the reporting is not adequate. This is more pronounced in case of reporting of suicide (Marahatta et al., 2017).

5.7 Poor Mental Health Literacy

Mental health has been described as a 'behind the scenes' issue by public and policy makers. Most of the Nepalese people do not view mental health issues as diseases, disorders or health problems. They view these as spiritual issues that in turn leads to minimal help-seeking behaviour indicating low levels of mental health literacy. The most concerning fact and a challenge is people are not aware of the available treatments for mental disorders as well (Shakya, 2016).

5.8 Lower-Middle Income Status and Income Disparity

Social factors like poverty, internal migration, urbanization, and lifestyle changes, are moderators of the high burden of mental illness in many LMICs and same is true for Nepal too. The high incidence of mental illness and substance abuse disorders Nepal has lead into an economic trap of disease burden. Determinants of mental disorders like poverty and income disparity are common in Nepal and pose as challenges.

5.9 High Stigma

A cross-sectional study among 180 patients with mental illness attending a psychiatric Outpatient Department (OPD) showed a prevalence of self-stigma to be present among 54.44% patients (Maharjan & Panthee, 2019). A qualitative study conducted in a district of Nepal identified stigma as a combination of lack of knowledge (ignorance and misconceptions), negative attitudes (prejudice) and excluding or avoiding behaviors (discriminations). The stigma was prevalent in the community and acted as a barrier for service utilization making it a challenge to mental health care (Devkota et al., 2021).

5.10 Non-judicious Prescribing (Poly Pharmacy)

Non judicious prescribing of psychotropics by other specialists and polypharmacy by the psychiatrist has also been a major challenge in day to day clinical practice in Nepal.

5.11 Administrative Difficulties

Administrative challenges have further complicated the delivery of proper mental health care. To execute the action plans effectively, the provincial and local levels of government require a well-trained and capable civil service workforce which is lacking. There are other administrative problems like corruption, fiscal indiscipline, political instability, lack of good governance etc. (Shrestha, 2019).

5.12 Scarcity of Medications

A qualitative research among primary health care workers identified shortage of psychotropic medicines in primary care setting, high workload, lack of private space for counseling, and grievances of health workers regarding incentives to be major barriers and challenge for the treatment of mental health issues at the primary care level (Upadhaya et al., 2020). Though many psychotropic medications are in free medicine list of government, they are unavailable at places and if available due to lack of trained manpower, have not been used.

5.13 Lack of Collaboration in Non-health Sector

Nepal has very poor mental health integration into non-health sectors. Though some development has been seen like gender-based violence, child protection, and disability management are increasingly including mental health components but still more needs to be done. Migrant worker health programs also have very little involvement of mental health.

6 Potential Ways Out for Nepal

There is a compelling rationale for the government and other stakeholders to consider prioritizing investments in mental health care for the country's population through evidence-based mental health promotion, prevention and treatment through accessible and affordable services. Under the context of ongoing continued efforts on advocacy, implementation and experience in the country around mental health, there is an enabling policy environment and receptivity about the importance of mental health across the stakeholders. To build on this landscape, there are key thematic recommendations that can play catalytic roles in making a substantive contribution to making mental health everyone's business in the country.

6.1 Human Resources Development and Distribution

For this there is a need to increase the capacity of mental health care workforce as well as infrastructures for mental health care. Also the distribution of services should be equitable.

6.2 Awareness Creation Targeting the Mental Health Literacy

One of the ways to reduce stigma and raise awareness is integration of mental health into the school curriculum, conduct awareness-raising programmes and implement the Social Emotional Learning (SEL) interventions modelled in the investment case via the Ministry of Education. The mental health literacy would improve if the people are educated at a younger age. Also, there is a need to educate traditional healers on which cases to refer and when as a part of collaboration.

6.3 Augmented Research and Funding

The research and fund for programmes need an upliftment. Research units need to be established in the academic institutions which can develop culturally contextualized and cost effective interventions and foster scientific evidence generation on mental health,

6.4 Health Insurance

The coverage of health insurance needs to be made in all districts of Nepal and mental disorders need to be covered in them.

6.5 Functioning Referral System and Information Management System

The referral system should be functioning at an optimum level. This would help in decreasing the work pressure at tertiary facilities and would empower lower tier of health system like primary care center and district hospitals. Additionally, creating a well synchronized and centralized information management system for continuous surveillance of data and rigorous monitoring and evaluation of mental health programmes will immensely contribute to quality service delivery and improved outcomes.

6.6 Availability of Psychotropic Medications

To increase the access to psychotropic medications we need to develop an efficient, functional drug procurement and distribution system and ensure regular availability of essential psychotropic medication as outlined in the Essential Medicine List across primary care clinics. This would make mental health care more affordable.

6.7 Inter-Sectoral Collaboration

There is also a need to promote the interface of mental health with other priority public health and social protection programs such as maternal health, TB, HIV, One Stop Crisis Management Centers (OCMC), emergency preparedness and response readiness.

6.8 Protection of Human Rights

As Nepal lacks mental health act, its high time we endorsed mental health act for the protection of rights of mentally ill people.

6.9 Disaster Preparedness

We have realized the toll disasters can have on mental health system in the earthquake of 2015 and COVID-19 pandemic, hence proper disaster preparedness is must in Nepal.

6.10 Suicide Prevention

Regarding the suicide prevention strategy apart from prioritizing implementation of population wide and targeted interventions for suicide prevention there is need to implement the regulatory ban on highly hazardous pesticides and ban other hazardous pesticides via the Ministry of Agriculture. We also need to strengthen school health initiatives to promote socio-emotional learning of adolescents including interventions against bullying and child abuse. There is also a need to develop culturally appropriate interventions for Nepal.

Finally, investing in robust national governance systems for mental health will provide the necessary framework for effective and sustainable mental health care practices. By implementing these strategic recommendations, the government can play a catalytic role in making mental health a shared responsibility and significantly improve the well-being of the nation's population. The way out can only be achieved by ensuring multi-sectoral coordination and community engagement to promote mental health, foster help seeking and reduce stigma and discrimination.

7 Conclusions

Nepal, a small landlocked country in South Asia between China and India, has a large population residing in rural area and are deprived of mental health care. The majority of mental health services is concentrated in major cities. There is increasing awareness and investment in mental health system both from private and government sector especially after the emergencies like the 2015 Nepal earthquake and COVID-19 pandemic. Despite improvement as compared to past, Nepal still faces challenges that a LMIC faces and some specific to the country. With an aim to strengthen mental health services at the all tiers from primary health care centres to tertiary hospitals and academic institutions there is need for training of specialist providers, investing in research for generating local evidence, implementing mhGAP in the primary care setting and making provision of psychosocial services throughout the country.

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